Psyche in Soma:

An investigation of the assimilation of conflicts in in two psychotherapy clients with functional abdominal pain

Volume II

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CHAPTER 6 CASE STUDY TWO

6. 1 Case Description and Background

Lore was a bright, attractive young woman referred by her gastroenterologist for repeated episodes of painful IBS over the previous three years. She appeared a much younger woman than her twenty-eight years. Lore was an only child and still lived at home with her parents. At the time she entered therapy, she was engaged. She had worked as a secretary in a busy city council office for several years; she was proud of her position within the organisation but was seeking advancement. Her current physician believed that functional abdominal pain was a better diagnosis for Lore, as her symptoms had not responded positively to three attempts to medicate and two series of medical investigations were negative in findings. This was understood to mean that her current physician perceived Lore's symptoms to be more psychologically based, compared to some other IBS patients. Lore herself understood her condition as irritable bowel syndrome, from previous conversations with her doctors, and agreed that pain was the predominant symptom which both disabled and distressed her.

Lore was primarily troubled by her chronic abdominal pain, along with other, more transient gastrointestinal symptoms consistent with a diagnosis of irritable bowel syndrome. Pain was the primary concern, however, as it nagged at her in a fairly continuous way, and periodic and more severe episodes would occur and impede her ability to function well, although she attempted to fight her experience and carry on as usual, as much as she could (e.g. she rarely took time off work). It was the disability created by attacks of pain that bothered Lore the most. Her usual response was not to let on to others that she was suffering, until she could get home to bed. Wanting to cope better with her pain and possibly be able to reduce it were the reasons why she entered therapy, and she mentioned that she had already been considering seeking therapy or counselling as a way to learn more about how she could handle stress, as she felt this was somehow related to her symptoms.

The assessment interview with the therapist revealed that she had attempted to examine different contingencies related to her pain: diet content and amount, activity level, exercise, menstruation, family events and 'stress.' She did believe her pain episodes were related to both menstruation and stress. She also suffered

from cramps and irritability during her period. This was a qualitatively different kind from her abdominal pain, but she understood that hormonal shifts did affect her digestive chemistry for a few days. Her ideas about stress were somewhat vague, in that she liked working hard and being busy but realised that she did sometimes feel stressed at work from task demands and time pressure. The latter were not perceived to be under her control.

Lore mentioned related illnesses in her family. In addition to her father's sister's fatal illness with intestinal cancer, her father also suffered from a chronic abdominal complaint (unspecified) which caused pain and occasional dysfunction. In Lore's family, somatic pain and illness were permitted a presence, and required special care. Emotional pain, although occasionally expressed, was more often kept hidden and social expression was kept to a minimum, a practice that Lore herself felt was unhealthy.

Lore attended for 17 sessions of therapy over a six-month period.

6. 2 Findings from psychometric measures

The results of Lore's psychometric and pain measurements are given in Table 6.1.

6. 2. 1 Illness and health beliefs, defensive style

6. 2. 1. 1 Illness Perception Questionnaire. At baseline Lore scored 9 points out of a total of 24, indicating awareness of symptoms (mean frequency rating of 0.75) and belief that they were part of her illness condition. By outcome, Lore's illness identity score increased slightly (11 items, mean frequency = 0.92). This was consistent with her experience of depression at the end of her treatment, and her relatively new experiencing of different types of related symptoms and sensations.

At baseline, Lore indicated her belief that her condition had some impact on her self-concept and social functioning (consequences mean = 2. 57); this corresponded to her presentation at intake. This impact had increased very slightly by the end of treatment (mean = 2. 43; *note* that in the mean range of possible responses, 0 = belief in maximum impact and 5 = belief in minimum impact). At baseline, Lore's

Questionnaire	Baseline score	Outcome score	Change or description of results
Chronic Pain Grade Questionnaire Pain intensity Disability points Pain Grade	 70. 0 2. 0 II	 56. 7 2. 0 II	Reduction in pain intensity, but no difference in pain grade
Personal symptom scale	15	6	Reduction in symptom severity and frequency during sample week preceding administration
Defensiveness Index Marlowe-Crowne Index Taylor Manifest Anxiety Scale	 19 16	 --- ---	Combined score indicates moderately anxious – defensive style
Beck Anxiety Inventory	12	18	Moderately anxious at both administrations and increase in symptoms by outcome
Beck Depression Inventory	13	16	Mild-moderate depression indicated at both administrations, with slight increase in symptoms
CORE TOT Well-being Physical functioning Functioning (social, life) Risk	 1. 44 2. 25 1. 75 0. 07 0. 00	 1. 50 2. 50 0. 42 1. 83 0. 00	Clinically significant score at baseline with trend toward increased distress at outcome
EUROQUOL Profile Weighted scores Self-perceived health status	11121 0. 796 50	11111 1. 000 70	Decrease in symptom profile between baseline and outcome; global increase in quality of life
CSFBD Tot = Mean =	148 5. 92	135 5. 40	Decrease in both frequency of concerns and degree of perceived worry
SUIP themes self understanding (mean)	12 2. 83	14 2. 93	Increase in *number* of themes selected, but increase in *self-understanding*
IPQ Illness identity Time -line Cause Consequences Control / Cure	 0. 75 3. 00 3. 00 2. 57 2. 00	 0. 92 4. 00 3. 10 2. 43 3. 00	Increase in identifying common symptoms as part of illness; Increase in perceived control, belief that illness is time-limited, only slight increase in self-causation, and slight decrease in confidence that impairment will be problematic.

Table 6.1 Psychometric and pain scale findings for Lore

illness cognitions indicated a variety of causal beliefs, including the belief that her state of mind contributed to her illness. She was undecided about whether or not her illness was going to last a long time, and expressed this confusion in her thinking by marking primarily *don't know* responses.

At outcome, her belief that multiple factors created her symptoms increased slightly, and now included interpersonal (i.e. social interactions) causes. She felt more certain that it would improve with time. She indicated slightly more agreement that it impaired her functioning, but her belief that she had self-efficacy in limiting those impacts had increased. This improvement was particularly important and contrasts with the finding that as Lore was clinically depressed at the end of therapy, and so her belief in self-efficacy regarding the control of her physical – and psychic – pain was also significant to her as well.

6. 2. 1. 2 Weinberger Index. At baseline Lore's Marlowe-Crowne scale score was 19, putting her in the upper half or middle third determined both clinical and non – clinical sample means as a cut-off in the studies cited above. Her TMAS score was 16, putting her in the middle third (moderate anxiety) of comparable samples. Together, these scores revealed a tendency to be moderately anxious, and moderately defensive. It is worth noting that individuals who have scored as high defensive – high anxiety have been difficult to conceptualise in research studies (i.e. they are aware of their tendency to be socially anxious and worry about impression management, so they are not repressors; but they employ other avoidant defenses consistently in order to manage their anxiety), and their numbers tend to be smaller than the other three groups (e.g. Esterling et al., 1993).

6. 2. 2 Psychological symptoms, well-being

6. 2. 2. 1 Beck Anxiety Index, Beck Depression Index. Lore's BAI revealed mild anxiety at baseline which increased by outcome (BAI scores = 13 and 18, respectively) Lore's BDI at baseline was 13, increasing to 16 at outcome. These scores indicate mild depression at both administrations. Her baseline findings, combined with her repeated presentation of feeling cheerful and making self-confident statements supported the idea that Lore was masking a low level depression at this time. The

increase on both measures indicating an increase in both anxiety symptoms and depressive experiences was consistent with a shift in Lore's increased experiencing of negative affect at the end of therapy.

Although a scoring system for evaluating the *affective*, *physical symptom*, and *self-denigration* factors found in the Morley, de Williams and Black (2002) study has not yet been developed, an item analysis was performed with Lore's BDI scores. It revealed that an increase in her score at outcome was due to an increase in affective symptoms (at baseline = 3; outcome = 8 out of a possible range of 0 - 24) while her self denigration scores slightly decreased (at baseline = 6; outcome = 4 out of a possible 0 – 18) as did her physical symptom scores (baseline = 4, outcome = 3 out of a possible 0 - 21). Thus, her profile indicated that affective and self-concept factors accounted for her depression scores more than somatic ones, unlike the profile for a large chronic pain sample (i.e. median score of 3 on the self-denigration factor) established by the authors above.

6. 2. 3 General health status and impacts of illness

6. 2. 3. 1 Clinical Outcomes Routine Evaluation. Lore's CORE at baseline was higher than the level needed for clinical significance (Total mean score =1.29 for adult females). It had not changed by outcome (the difference between these two administrations was not significant). Her Well-being, Physical functioning or problems, Life and social functioning scales were also clinically significant at both baseline and outcome, with only risk remaining insignificant.

There are two ways in which this finding is important. First, this measure is consistent with Lore's experience of her anxiety and depressive symptoms and some changes in her experience of them by the end of her therapy. However the nature of her experienced problems did change, and this measure was not by itself able to reveal this difference. Second, Lore's problems at the start of therapy had already taken a psychosocial focus within her own thinking (even though her understanding was vague); and part of her learning involved a more precise understanding of the dynamics involved in these conflicts.

6. 2. 3. 2 EuroQuol. At baseline Lore's EuroQuol indicated no problems with health except for moderate pain (i.e. profile 11121; weighted score of 0.796), and that she judged her overall health status to be exactly midway between the 'worst' and 'best' imaginable health states (score = 50). By outcome, her profile had changed, and indicated no significant health problems at all (even profile, weighted score of 1.000), but her overall health status rating had increased by 20 percent (i.e. 70 per cent of the way towards her best imaginable health state).

Thus, Lore presented an attitude of improvement, which translated across her well being and symptom –based scales. However, at the time she responded to this measure, she indicated 'no problem with anxiety or depression' although her BDI indicated moderate level of depressive symptoms. This discrepancy between her response on the Euroquol, and her BDI along with her own reports of affective disturbance may reflect how different items, and their contexts may draw differential responses. On the EuroQuol, in which she was asked other statements about her functioning (i.e. mobility, self-care, activities, pain) and her overall health, she may have considered her more generalised (and improved) state of adjustment and understanding as a lens through which to interpret the statements related to depressed/ anxious feelings. On the BDI, and in interview, her responses were directed more specifically to her experiences of depressed affect.

6. 2. 3. 3 Cognitive Scale for Functional Bowel Disorders. Lore scored totals of 148 on the CSFBD at baseline, indicating that her concerns related to her bowel problem and associated psychosocial problems were both prevalent and problematic. On the 25 item scale, her ratings were at least 3 on the 7-point scale (indicating the *least* degree of disagreement). On 22 items she offered slight, moderate or strong agreement that her functioning was impaired by her illness or other worries about her interpersonal relationships, with an average degree of concern of 5.92. Social humiliation or embarrassment featured in the statements with which she agreed most strongly.

At outcome, this score decreased to 135, indicating a reduction in the degree to which individual problems associated with her illness affected her functioning and comfort. At outcome, her ratings on 4 items had remained unchanged; 2 had increased one step (representing a stronger concern), but 9 had decreased between

1 and 2 steps (indicating less concern than at baseline), with an average of 5.40 on a 7- point scale.

6. 2. 4 Pain measurements

6. 2. 4. 1 Pain Symptom Scale and Chronic Pain Grade Questionnaire. These results offer a wider context in which to view Lore's pain experiences and their change between beginning and end of therapy. Her Chronic Pain Grade remained at II between baseline and outcome, but her pain intensity score decreased from 70.0 to 56.7 (the latter score was close to the border with Grade I). A similar picture of change involved the intensity and frequency of her perceived symptoms (score of 13 out of 20 at baseline decreasing to 10 at outcome) whereas her dysfunction score remained at 16 across both measurements. In the Grampian population study, of those patients indicating a problem with pain as indicated by a Pain Grade rating > 0, approximately one third received a Pain Grade of II, and those receiving stable Grades of II over a 4 year follow-up study were approximately 59% (Elliott et al., 2000).

This result mirrored her pain experience, which did decrease as the six-month period progressed. Lore's baseline Personal Symptom Scale yielded a score of 15, indicating moderate severity of worst pain approximately 2 days a week for her *unbearable pain* experience, and a more frequent (5 days) but less severe (level 3) *nagging with nausea* pain. At outcome, her total Scale score had reduced to less than half of her original score, with her worst *unbearable pain* at level 2, a single day in the previous week and nagging pain with nausea at severity level 2 one day during the week

6. 2. 5 Interpersonal Problems

6. 2. 5. 1 Self-Understanding of Interpersonal Problems. Lore's SUIP at baseline revealed 12 chosen items (out of a total 19), with an average self-understanding rating of 2.83 (range of 1 – 4, with one indicating least amount of understanding, and 4 indicating an awareness of the transference between current and past events, and an understanding of reasons why the concern exists). The selected statements revealed themes of dependency and its conflict with desiring independent choice and action (e.g. *I need someone to take care of me, and I feel abandoned when he/*

she is not helpful; I need to be respected by someone, and I feel hurt when he/ she does not approve of me), needing acceptance and affection and its conflict with individuation and setting appropriate boundaries with others (e.g. *I am very dependent on others for approval, and feel hurt when they reject me; I need someone to truly understand me, and feel hurt when he/ she cannot relate to my feelings*).

By outcome, her chosen items had increased to 14, but her self-understanding on the 12 items previously chosen had increased to a mean of 3.00 (range of 2-4), with an overall mean (including two new items) of 2.93 (range of 2 – 4). These new items offered her broader awareness of how Lore was motivated by the need to please others (in order to maintain closeness and affection) or keep others close, even when it hindered her – or another's – growth.

6. 3 Therapeutic Formulation of Case and Therapy Process

In this section, the therapeutic process as experienced by Lore's therapist (the author and co-analyst in the further analyses which follow) will be described. This will include the case formulation and descriptions of therapeutic movement, with a reformulation of Lore's gains and current functioning at the end of therapy. The case formulation included her therapist's ongoing view of Lore's psychological dynamics and interpersonal conflicts, and hypotheses about the relationship of pain to these psychological functions. They were grounded in both psychodynamic and attachment theories (e.g. Kohut, 1977; A Freud, 1937: 1966) with some concepts drawn from experiential therapy (e.g. Greenberg, 1996; Clarke, 1989).

6. 3. 1 Initial impressions and client focus

Lore's youthful and vigorous manner were very salient in forming an impression of her, and reminded her therapist of an adolescent just blossoming into a time of identify, half child and half woman. Her presentation appeared self-confident and full of vigour. Her expressed concern was trying to solve the problem of her pain, but she was also uncomfortable with other aspects of her body, and worried about her weight and more generally, her appearance. She offered some evidence of avoiding strong emotion, except for an optimistic and cheerful outlook, although

she described herself as capable of getting quite upset and expressive with anger at times. However, these descriptions were offered with a sense of distance, as if Lore was talking about someone else. In part, the interpretation that Lore might be avoidant and defending against other feelings was based on a perception of underlying anxiety during her intake interview and assessment. She was aware that she was anxious; however, she revealed a certain lack of variation in her self - presentation as bright and happy, coupled with resistance to absorbing more negative views of self or others.

Lore easily talked about events that concerned her: in the early work these focused on her frustrations at work, and disputes at home with her mother, although even these were portrayed within a rosy picture of a pleasant enough environment. Her relationships were depicted as quite happy. Over the past year, she had become engaged to a young man her own age. They planned to marry not sooner than two years hence, when Lore felt she would be sufficiently ready, financially and emotionally, to leave home and start a new life with her spouse. Her therapist got the impression these plans had been devised by Lore; there was little sense of her fiancé as an active agent.

She recognised that she was anxious and the primary content of her concerns involved her ability to keep her relationships happy and better establish herself in her career by achieving a movement up in position. She was frequently nagged by troubling thoughts that she would not succeed, and by somewhat vague impressions that she did not have the support she needed from her relationships, although it was difficult for her to complain.

Lore considered her attachment to family as exceptionally strong, even too strong. She stressed how much she needed them, and had difficulty thinking about the day she would leave home to create one of her own. She mentioned frequently that she was an only child, and believed the special closeness of this attachment with her parents was two-way. Other relationships were also a concern to her, and included friends, and co-workers.

Her therapist perceived that she appeared to be concerned with being seen as a pleasant, agreeable young woman, eager to please, and her therapist frequently

found herself experiencing the impulse to offer protective and instructive advice. She hypothesized that in part, Lore's unconscious (as well as her conscious presentation) may have stimulated this response, along with her own needs to offer mothering in response to the non-verbal expression of vulnerability Lore often exuded.

6. 3. 2 Formulation and therapeutic goals

6. 3. 2. 1 Self-regulation of conflicts and defenses against anxiety

During the assessment phase, it became apparent that Lore was engaged in more than one inner conflict, although their relationship was not yet clear. She was frequently anxious in her discussion about the necessity of maintaining close ties with her family and fiancé, as if it were under a chronic threat. Her narratives revealed her belief that special care and attentiveness were needed in order that relationships did not get lost or damaged. She realised her relationships with people were sometimes problematic especially when she felt herself to be dependent on others. Separations and abandonment surfaced early as threats for which Lore was only partially aware.

Being dependable and predictable (to herself and others) seemed to be a way Lore experienced trust, and trustworthiness to others; deviations were experienced as *'letting herself – or others – down.'* Early on, her therapist hypothesised at times they also became part of a neurotic solution in an attempt to secure her relationships and *deserve* approval; being careful in her performance and reminding herself of how much she needed others for well-being kept her vigilant about the impressions she felt she made on others. This style of self-regulation (i.e. a common way Lore kept her sense of self-esteem and self-worth at a reasonable level) was not moderated by real interpersonal feedback, however, but more constantly affected by her anxiety over what might happen if in some way she became neglectful or sloppy in the management of her expressed caring for others.

The therapist noted on multiple occasions that at times she felt she was sitting with a teen-ager, and felt an inner pull to be protective or give life advice at times. Lore

herself acknowledged that she felt developmentally immature, not quite ready for the tasks of adulthood. She maintained a consistently bright, sunny attitude during the first half of her therapy, although she was somewhat anxious in her presentation; this was observed by the therapist as an eagerness to be a good client, consistent with her regular persona.

Overall, the therapist felt that Lore was grappling with delayed adolescent tasks of development, and that she showed a preoccupied form of attachment (Bartholomew & Horowitz, 1991). These early impressions and subsequent intra- and interpersonal dynamics in her narratives were felt to fit a narcissistic pattern (Kohut, 1977; Reich, 1949), with a fairly continuous need to maintain a feeling of security and approval and defend against feelings of failure or isolation. These concepts jointly constellated the formulation that she was struggling with the tasks of achieving identity and establishing interpersonal boundaries and values; and that her chronic somatic pain might be related to problems in achieving these tasks, perhaps in more than one way.

6. 3. 2. 2 Developmental history and attachment issues

Lore had grown up as an only child with both parents in a rural and affluent area in Perthshire. She drew an idealistic picture of her childhood, and spoke of it longingly, saying that although she did want the responsibilities of an adult, she realised the loss of being able to depend on strong parental figures who could take care of her when she needed them to. Lore still depended on her parents for financial security and both physical and emotional care-taking. Although she was saving up her salary in order to buy a house eventually with her fiancé, and was quite proud of the symbols of adulthood which made her feel grown –up (i.e. her own car, stylish clothes), she was also reluctant to leave her 'nest' at home, and spoke longingly of the carefree days of her own childhood. Her current relationship with her mother and father was ambivalent. On the surface, she continued to speak of theirs as a contented home, and how much she liked living with her parents, who treated her well. At times, however, she described undercurrents in her relationship with her mother, who was reported to be envious of Lore's job and some of her accomplishments. Lore described occasional arguments, in which her mother accused her of being selfish. At other times, her

mother was portrayed as over-controlling and in disagreement with Lore's choices of dress and friends.

Lore discussed other relationships within her extended family, primarily her grandmother (who had died some years ago) and a female cousin. These women, in addition to her mother, were also presented as critical influences in her life, who voiced disbelief that Lore would ever be as accomplished as her cousin, who was studying for a PhD in Glasgow, or rise above her station as a company secretary. Lore had been hurt by these exchanges, and they remained in her memory as frequent occasions, which continued to hurt her. Another response was to become defiant and focus on her plans to climb the job ladder to personal assistant, and dream of acquiring the life-style of the models and successful business women that were depicted in the glossy women's magazines that Lore read. It appeared that inwardly, Lore alternated between a fear of non-achievement and the threat of never gaining the esteem from her accomplishments that she dreamed about, and identifying with her ego-ideal.

Lore had been engaged to her fiancé for a year, and they planned to marry in a few years once they were both ready to establish a home together. This preparation appeared to involve the development of emotional as well as financial independence from their respective families (i.e. Lore's fiancé lived at home with his parents as well, and was reported to be less career-orientated than she was). Lore liked being in charge of planning their future, rather than being dependent on her fiancé, but this provided another example where she appeared to move back and forth between two poles in which she saw herself as either very dependent, or in charge of all responsibilities for others. She could not perceive what a more negotiated inter-dependency would be like at this stage of her development.

Her earlier experiences with loss included one previous relationship which spanned her late teens and early twenties. Although this relationship had ended amicably, she was unprepared when her boyfriend announced that he wasn't ready to settle down, and Lore experienced a sudden drop in self-esteem. She spoke briefly of the long period that followed in which she became depressed, and how her parents helped her through this period. Lore had not dated in high school, and had felt unattractive since her early school years. She recalled being bullied at a young age,

and although this experience was only occasional, she felt its impacts lasted throughout her school days. She only began to feel confident socially in her twenties, after she got a job with the council and received good feedback about her work.

In relation to these periods of psychological distress and her physical symptoms, Lore could talk about her problems directly, expressing partial awareness of the conflicts that underlay her concerns Her concern over not achieving became a continuous stream among the topics in her early narratives. She worried, excessively by her own admission, that she would not get the opportunity to achieve the job and status she craved. Occasionally doubts about her abilities would creep into her narratives, although were usually attributed to the environment, such as others at work or familial relatives. Although her desire for further achievement in her work goals and financial worth were reasonable goals for a woman of Lore's age and employment history, there seemed often to be a compensatory aspect to her expression of these goals. Her striving, and frequent reference to somewhat idealised images of a future *self* appeared to increase her self – esteem, at least temporarily. These images needed relatively continuous stimulation from Lore's environment (e.g. she was attracted to, and spent time thinking about powerful others) and it seemed that when they paled, Lore's affect became depressed.

6. 3. 2. 3 Role of pain in obstructing life goals

Lore's desire to be active and predictable was obstructed by her pain episodes. Most of all; the distress and disability she experienced during episodes prevented Lore from acting and thinking in a forward moving way, and left her wanting to take to her bed (i.e. to become unconscious). The therapist heard this in a symbolic way, as the struggle for individuation was tiring and demanded heavy emotional costs for Lore, who at times felt the pressure to delay or give up the struggle altogether. Yet other impulses and desires to grow up and achieve would not let her do so.

6. 3. 2. 4 Therapeutic goals

By the end of the fourth session, the therapist discussed the following goals with Lore for their work. The main tasks of therapy involved two interrelated goals:

- To help Lore come to some understanding about factors related to her experience of pain, and

- To develop more sensitive awareness of her own feelings and needs, and to learn to respond to them in a more discerning manner.

- To begin to help her establish more distinct interpersonal boundaries, in order to gain more independence from enmeshed relationships with others. While the latter was not an initial reason Lore brought into therapy, it became a focus in the work.

The main emphasis of this work, given the brevity of the therapeutic contract in relation to the perceived pervasiveness of her developmental needs and conflicts, was to help Lore continue to clarify what were her own personal values, and create a strong enough relationship to provide containment in order to explore a greater range of personal feeling experience in relation to ongoing events in Lore's life.

6. 3. 3 Significant processes associated with movement during therapy

6. 3. 3. 1 Therapist understands the role of manifest anxiety in maintaining defenses. When exploring aspects of her *self*-experience, Lore did describe herself as an anxious person. She called herself a *worrier*, becoming excessively concerned about what others thought of her. Blemishes in her skin, messy bodily functions such as defecation or menstruation, or volatility of mood were all causes for spells of anxiety, and efforts were made to control if not conceal these parts of herself. Her anxiety was experienced as long episodes of negative self-talk (e.g. *My face really looks a mess; I don't know what I'd do if I got an attack of diarrhoea on the train, it would be too awful*) and inhibitions in subsequent behaviour. Her presentation remained anxious much of the time. Lore felt this was simply intrinsic to her

character. Her therapist felt it also acted as an outwardly defensive and vigilant strategy to avoid or protect herself from potentially negative events in the environment, by avoiding a deeper and problematic experiencing. Fretting while maintaining outwardly compulsive behaviours to appear pleasing and compliant helped her avoid difficult impulses or more intolerable sources of anxiety within, and acted as a magical prevention against others' attacks of anger, envy, or disappointment. In order for Lore to perceive these functions, she would need to be able to distance from and reflect on these aspects of her behaviour while accepting that she enjoyed feeling cheerful and positive as real values as well. It was not until the second half of her therapy that she was able to achieve this stance, however.

6. 3. 3. 2 Linking chronic anxiety to deeper chaotic fears. Lore expressed similar inhibited and compulsive attitudes about her work outputs. Demonstrating efficiency and dependability in her work continued to be causes for concern, even though there was little external cause for it. With just a little exploration, Lore recognised that most of her performance anxiety came from within. As her narratives involving work and social domains began to reflect similar themes across events, the therapist reflected that certain repetitive issues might provide a stage allowing Lore to access a deeper understanding of her own defensive strategies. One involved her reactive dislike and rejection of anything that got in the way of keeping her life *ordered.* On occasion, she began to acknowledge that maybe her need for tidiness, brightness and efficiency weren't simply fine personal habits, but in fact got in the way of being able to live more comfortably with others and establish reasonable expectations of herself.

An early domain in which she was able to separate her thinking from her automatic defensive process involved her working hours. Lore had mentioned on several occasions that she worked flexi-time, and could choose her own working hours within a given range. Nonetheless, she had been unable to alter her habit of working from nine to five o'clock, even when she needed to leave an hour early for a doctor's appointment or because something equally important intruded. She argued with herself in two sessions, and found she could take both positions (her usually rigidity over her hours and the validity of changing them), and realised she was tethered to an unreasonable self-demand to act consistently. She feared

suffering reprobation from others; in her fantasy, they might suddenly see that she was not as dedicated to her job as they imagined. When one day she did leave at four in order to meet a chosen appointment, a co-worker did remark on this, as it was an alternation of Lore's behaviour. In the next session and with help, she was able to see that the remark was more probably based on the co-worker's curiosity over what Lore was doing, rather than a criticism of her work effort. Lore also came to see that underlying this particular concern was a long-standing feeling of competition with this co-worker she had avoided perceiving until now. Thus, Lore began to see that her insistence on other generalised and rigid perspectives about herself and others had become a way of avoiding excessive anxiety over personal failure and rejection.

These gains in therapy assisted her recognition that she had been fighting against realising negative views of herself, and attempted to avoid feelings of anger, jealousy and envy at times. By the time she terminated she was better able to accept her darker emotions and own her own feelings of aggression. These gains helped her accept her need to grieve for the loss of a major relationship near the end of therapy, and recognise a more latent sadness and anger that had been residing within.

6. 3. 3. 3 Client perceives own use of defenses and conflicts underlying them. As Lore became more relaxed with her therapist, and her ability to perceive her acceptance grew, she began to look at how these habits *defended* her against experiencing even greater discomfort, and learn more about the impulses and fears successfully warded off. She discovered that she feared getting trapped in her current circumstances, longing for a better and more fulfilling life but never getting the opportunity to achieve personal and work recognition she craved. These fears and the associated pain were experienced as deep and barely tolerable. In time and with a sense of being contained in the session (i.e. within her relationship with her therapist, away from her usual domains), she began to explore her responses with less anxiety. This enabled her to identify a conflict between experiencing herself as a closely maintained, pleasant public *face*, and experiencing herself in a more variable way, including moody and potentially angry or rejecting, and allowing a more instinctive and variable centre to guide her presentation of *self*. Lore did not feel she knew this part of herself very well, and was cautious because at times, it

did appear to come to the fore and created trouble for her. She was able to relate examples in which she became fraught and angry, and sometimes self-destructive (i.e. pulling at her own hair in frustration). When she encountered similar energy in others (e.g. her mother) it was also difficult and she felt emotionally harmed by it. Her ability to accept this conflict came with her admission that it was sometimes a strain to keep a bright and positive attitude, and that other feelings and attitudes were also inner realities that had been ignored.

6. 3. 3. 4 Need for others for regulation of esteem and self-worth. Lore's rigid pattern of self-presentation was considered by her therapist to be a facet of a narcissistic personality organisation (Kohut, 1971), in which her own inner structures could not reliably regulate her self-esteem and belief in a benevolent world. Thus, she was over-dependent on her environment to provide this function, and attempted to act in a way that would secure it. While the therapeutic relationship could not act as a replacement for the parental one, it could address the needs for *mirroring* and *idealising* that had not been satisfied. This theoretical point will be discussed in more detail below. As a therapeutic task, Lore needed to see the degree to which she had viewed others as what she needed them to be, in order to develop stronger concepts of self and others (i.e. an internal *self* and *objects*), that would allow her to relate to others as separate people existing outside of her own needs.

It also helped Lore see that her positive and carefully managed presentation of *self* did not prevent her from experiencing others' rejection and anger, although she had felt puzzled by the unfairness of this when it happened for a long time, and became a focus for her experiencing of *self* when it did. With her therapist's help, she began to re-evaluate how much control her defensive *persona* held over interpersonal events, and contemplate the basis for others' motives towards her that were not based on what she attempted to offer them. One gain in therapy included her ability to see others as more separate from herself and her own wishes. She began to understand that where she lacked her own values or awareness of self, or was unable to perceive herself as an active agent in interactions with others, she was more likely to find herself feeling victimised by their claims that she had been inconsiderate or incompetent. This was not an easy shift in perspective, as it required her to accept her own anger and disappointment that others had behaved

irresponsibly towards her, which was even more difficult to assimilate than her own proposed guilt.

6. 3. 3. 5 Conflict between need for dependency and need to establish separate *Self.* Lore was partially aware of her need to feel close to others, and that she experienced insecurities over maintaining closeness. Her reported response to earlier bereavements revealed still-painful losses (e.g. her family dog and a favourite aunt died at the time her pain episodes began, and Lore recognised she was still grieving and needed a replacement for these lost objects). As she re-experienced events involving her dependency on others in session, Lore realised that her need for continual closeness or ensuring approval through compliant behaviour interfered with her ability to ascertain her own preferences and choices in certain situations. In addition to her emotional dependency on her fiancé and financial – and emotional – reliance on her parents, she began to realise that this reliance had also meant that others could define her goals as well. This served to fill the gap, when she felt unsure of, or out of touch with, her own ideas about a course of action.

One cost of her enmeshed relationships was that it left her with somewhat insufficient interpersonal boundaries, and an inability to stand as a separate s*elf.* This rendered handling interpersonal conflict difficult, if not potentially destructive of Lore's self- esteem. Conflict was most painful on the rare occasions Lore's expression of *self* stood out (i.e. her stance did not reflect the choices of others) and this elicited perceived anger or threats. At times she described feeling like a *magnet*, that attracted others' emotional problems, and she felt she was expected to carry these problems in some way. Her therapist felt this was possibly a good metaphor for the experience of projective identification. Lore might be *taking in* undesirable feelings and motivations that others (e.g. her mother, her depressed co-worker) were not able to accept within themselves (e.g. *selfishness* from her mother, and *insensitivity to her needs* in the case of her depressed co-worker). Indeed these were also issues for Lore.

Dialogue about the workplace became an early venue for this work, as this was one ground where Lore was certain about some of her occupational and interpersonal competences, and she could begin the process of sorting what feelings or needs belonged to her, or others. Becoming more able to find her own feelings and

thoughts amidst projections from others (as well as conflict from more rigid dominating inner voices or objects) was facilitated by the therapist's interventions, combining a dynamic and more experiential approach. First, the therapist pointed out discrepancies that existed in her presentation (e.g. signs of anger, distress amidst strong, impression management by a cheery person coping well). Second, the therapist related her own feeling responses to Lore at particular moments, in order to provide an example of relating and sharing feelings within a boundaried and acknowledged relationship. The therapist also invited Lore to stay with confusing or unclear feelings, or episodes of pain or anxiety when these were situationally evoked and Lore was willing.

6. 3. 3. 6 Developing inner structures for regulating self-esteem. Lore needed to develop stronger inner resources for regulating her self-esteem. With assistance she became more aware of, and later could spontaneously reflect on how she used her own behaviour or relationships as defenses against the collapse of her self –regard. For example, she began to see how her compulsive shopping for better clothes or accessories or focusing her attention on idealised figures (e.g. successful young women) served this function. Lore had been attracted to glossy images of successful, pretty young career women, well admired by young men. To her therapist, this attraction appeared to be more appropriate for a teen-ager. For Lore, it appeared to serve an identification through unconscious fantasy. Seeing or achieving similarities to these figures could offer her a special and prized view of herself. At times, Lore's self-view was somewhat grandiose, rather than based in a more realistic appreciation of her abilities and limitations; at other times, it was filled with self-doubt and worry over her imperfections.

Kohut (1977) describes how narcissistic deficits may result from the lack of sufficient *mirroring* moments in early development. These are responses from others that offer a sense of being cherished for the child's unique self, moments of felt affection rather than pride for some accomplishment. They provide the feedback that the child has been really *seen*, and found special for the whole of who he or she is. Over time, an adequacy of mirroring responses from the environment helps the child develop a more cohesive sense of *self*, including a sense of boundaries (i.e. knowing what was relevant to the *self*) and at least some positive, hopeful self-beliefs (i.e. reflecting the child's competencies). The

supervisor and therapist agreed that Lore needed to understand her needs for appropriate feedback as her own self-concept became more stable and she became less dependent on the daily feeding of – or starvation from – positive self views from others. The therapist also performed this function for Lore, by highlighting perceived changes and holding them when Lore regressed or became lost in temporary periods of defensive isolation again. For example, the strongest early gains were made in her compulsive attitudes about her own work and those of her colleagues in her workplace. Lore began to gain greater access to her feelings, she spontaneously began to develop greater insight into the interpersonal and intra-personal issues that arose with her co-worker, and could better separate the two. This enabled her to better acknowledge and accept her own anger and irritation towards this lady with less fear and dread of her own guilt. More generally, Lore appeared more spontaneous and alive in these sessions, and her voice deepened in tone.

In working with Lore, her therapist was especially aware of the importance of accuracy in her reflections back, and allowed a responsiveness which mirrored her values and needs, and helped her evaluate experiences that were more fulfilling of them.

6. 3. 3. 7 Understanding pain and the various meanings of its expression. As one of Lore's goals was to better understand these episodes of pain, she and her therapist derived a mutual plan for examining the potential relationships between pain and other inner experiences. They decided to look at these episodes in two ways. First, they would track them, and explore Lore's associations and feelings around the time an episode occurred. They agreed they would not prematurely decide what should or should not be relevant to examine in these reviews. Second, Lore would work on ways of describing her pain (i.e. how she experienced it and how it made her feel), and her therapist would assist by facilitating, and perhaps linking these to any similar experiences in Lore's previous narratives. Compared to Megan, Lore was more open to exploring the ways in which her own behaviour and feeling states might correspond to pain episodes.

Repetitive themes that resulted in this review included a perceived increase in stress, due to what could only be vaguely defined as feeling *pressure* within a

social or employment context. Over time, she became better able to *sense into* her pain (both in and outside of session) as if she had fists inside her belly that were clenched, and remained locked in this posture except for the vibration of frustrated rage. She became better able to anticipate when her episodes would occur, which varied in intensity. Eventually she was able to see that two situations provoked pain regularly; one was when she anticipated, but then avoided a conflict with her fiancé (i.e. these usually involved Lore removing or inhibiting a request for her fiancé's attention, or ignoring information that he did not care devotedly for her). The other occurred when she returned to her more normal work environment (i.e. to a Cinderella-like and routine set of duties for her), following occasions where she took over for a personal assistant whose job she coveted and was allowed to fill when this lady went on holiday or was off work to recover from a depressive illness. Frustration and rage were tied to these experiences, as if part of Lore was being forced back into a small place within.

6. 3. 3. 8 Making changes in her life and relationships. However painful this process was, she herself saw this as a step forward, and the result of changes in both outer and inner circumstances brought on by her growing sense of *Self* and independence. Outwardly, this involved ending a love relationship, which had been unsatisfactory for some years, and facing the losses that she had avoided previously. In her inner life, this shift involved relaxing previous defenses against the great anxiety she had that once left to herself, she would find nothing there to sustain and nourish her. In her terms, she permitted herself the test to find out if she simply wasn't good enough to have the life she wanted. She asked for more changes to be made at work, and risked criticism from her superiors. Although Lore did feel concerned about the outcomes of these moves, she also felt better able to work with the accompanying self-deprecating thoughts and hopeless feelings that still occasionally arose as she took risks, and she discovered that she was less frightened of the power of her own thoughts and feeling to leave her in a hopeless state of depression. She did become clinically depressed, but offered her own view that her understanding of this period as a time of grieving and letting go was actually good, and she wanted to hold onto it for a while, rather than talking, acting, or medicating herself out of it. There was something more *real* and *hers*, about the experience. She was able to articulate that, as a state of being it was temporary, but was needed for her to make other changes. Mostly, she saw her

depressed feeling as a time to think and digest. As she was supported well at home and by friends as well as her GP, her therapist believed that Lore's decision to work with her feelings at this stage were appropriate.

Breaking her engagement with her fiancé was a major event near the end of therapy, precipitated and followed by an intensive period of therapeutic work. Lore moved more deeply into an understanding of the conflicts of which she had been barely aware. She realised she had more work to do, but also that first she needed to continue to re-build her sense of self and its security. She voiced these sentiments again at follow-up.

6. 3. 3. 9 Going deeper into buried feelings and accepting them as *self* At this time, Lore also began to see why she perpetuated unreciprocated relationships. As she became more distinctly aware of her own reactions to people and situations, rather than following a prescribed way of being, she became closer to more primitive and frustrated responses within, occurring when her needs were not satisfied. Images of rage and destructiveness accompanied the experience of frustration, and these were occasionally enacted in safe situations. Before therapy ended, Lore was closer in contact with this inner raging voice, capable of negative evaluations of others without guilt. This insight into and experience of another part of herself did not shatter her relatively positive view of her life, nor did it leave her feeling distrustful and paranoid toward others, but enabled a more realistic appraisal of both self and others, and more flexibility when she was dissatisfied.

The contrast between the beginning and end of therapy in Lore's ability to own and accept differing impulses within a consistency of self was exemplified in Lore's relationship with a co-worker in her office, who was referred to as *the depressed lady.* Lore's reluctance to ever name her was taken as an indication of her desire to protect her self-image as one who did not complain, say negative things or gossip about others. Until the second half of therapy, Lore could not let herself complain without a preface, such as *I know this is terrible to say,* or *I shouldn't put down someone who is suffering.* Near the end of her therapy, following a bout of criticism from this lady, Lore was able to own and express her responses to this behaviour, and feel relaxed about doing so to both her therapist and in a careful way to the lady herself.

6. 4 Voices Formulation and Assimilation Analyses

In this section, an assimilation analysis will be described. Voices were selected on the basis of expressed characteristics (e.g. vocal tone and other prosodic qualities, points of view or perspectives, expressed needs or desires or values, conflicts with other expressed views). First, the selection of voices for process measurement will be described, followed by the assimilation ratings for the emergent voices in two pairings or sets. Each voice pair and a movement away from dominance by one voice and growing acceptance of one or more problematic voice will be described in a further, separate qualitative analysis. Finally, in a case assimilation analysis a comparison of voice developments will be made.

Five voices were identified. These and their relationships are listed below, and they will be discussed in terms of sets (i.e. an emergent voice and its opposition by a dominant voice). In the first set (*IF – ACE*), another emergent voice, *Bully* is presented as well, as this voice was believed to be opposed by *ACE* (or alternatively, by *ACE's* conflict with *IF*), and its emergence beyond APES level 1 was dependent on movement within the *IF-ACE* axis of voice expression.

1) ***Always cheerful and efficient*** (*ACE*), a dominant voice in opposition to ***Instinctive Feminine*** (*IF*), an emergent voice

2) ***Child*** (*Child*), a dominant voice in opposition to ***Independent Adult*** (*IndA*), an emergent voice

3) ***Bully*** (Bully), an emergent voice kept repressed by both ACE and its conflict with IF, and also possibly by the *IndA -Child* voice set.

Box 6.1 Lore's voices and their dynamics

Segments in which *spoken hostile or denigrating criticism-out* or *–in* existed were extracted and pooled, and rated for this voice. When these were analysed, they also appeared to exist in opposition to either *ACE* or *Child* depending on the segment. In addition, this voice did not emerge consistently until some development of *Instinctive Feminine* and *Independent Adult* had occurred. Occasional intrusions of masochistic thinking (i.e. response to inner criticism and hostile anger) or hurt and demoralised response to others (i.e. bullies, envious co-workers) were early intrusions by *Bully*, and only later could Lore recognise this as her own inner voice

and response to others, and finally, begin to own her own aggressive impulses towards others. Both findings provided evidence that the identity of the *Bully* voice was repressed to a deeper level than either *Instinctive Feminine* or *Independent Adult.* It may also indicate that it was these other two conflicts that warded off this voice rather than simply the dominant voices in each case.

Similarly the structuring of two major conflicts, *IF –ACE* and *IndA-Child* came from an analysis of therapy dialogue; in particular what got expressed (both verbal and nonverbal behaviours) and the impact of these expressions on subsequent experiences of self, topical associations in therapy, and the nature of the cognitive (including emotional) reactions they provoked.

6. 4. 1 *IF – ACE* formulation

Examples of attitudinal perspectives expressed by each voice are below in Table 6.2.

IF:	**My body and its responses are real and important sources of information about myself.** **I accept and need to express my feelings, including rage and anger and painful feelings.** **I am proud of my body, and want to express its feeling including my sexual being.**
ACE:	**I must always be bright, cheerful , industrious and efficient.** **I must not become irritated.** **(Impulsive) feelings should be resisted; they make trouble.**
Bully:	**I want to strike out and hurt when I am frustrated.** **I want to criticize and blame others when I cannot see what to do.**

Table 6. 2 Attitudinal perspectives expressed by each voice (Lore: *IF – ACE – Bully)*

Instinctive Feminine (IF) was a voice that, in Lore's own experience arose from a deep centre, and was concerned with her developing and establishing her feeling-based femininity. When it was assimilated to late level 2 or 3, this voice was expressed clearly, and Lore sense of self broadened; her voice deepened, she was more relaxed in her presentation. Her need for power and control in her own affairs and relationship to others was based on the ebb and flows of her own needs that arose within a more natural rhythm of activity and rest, social connectedness

and self-absorption. Later on, Lore associated these aspects as part of her feminine being.

IF connected Lore to her capacity to permit the experience of, and use instinctive, intuitive feeling, including anger and disaffection as important sources of information about how she responded to others. Her sources of knowledge included pre-verbalised and unsymbolised forms of information associated with spontaneous body-based sensation and emotion. Theoretically, a voice representing *instinctive feminine* inner resources could describe a number of more specific, distinct voices, based on feeling qualities, but for Lore, this whole stance provided a distinct voice, with the capacity to express a variety of emotions. As the dominant voice opposed to it incorporated perpetual cheerfulness, *IF* was associated more often with the expression of disaffection, anger, and disapproval, or a negative feeling-based evaluation (*not good, not for me*) towards people or events. However, it could also offer moments of joy or humour that *ACE* might not permit.

By contrast, *Always Cheerful and Efficient* (*ACE*) represented a fairly rigid persona, and dominated her expressed relations with others. Initially, Lore's belief in and expression of a sunny attitude was almost intractable. Her cheerfulness, expressed by her smiling face and declaration of positive outlook was continuous and reflected a 'bright' attitude, towards most anything. Week after week, there was little variation in Lore's behaviour and dominant voice as she entered the room, even when she was describing something painful. This persona reminded her therapist of the film characters from the 50s and 60s portrayed by the actress Doris Day.

The *Bully* also represented another partially repressed voice, that was related to this voice pairing and analysed as existing at a deeper level than *IF.* Its primary features included hostile anger, arising from frustrated needs and the desire to hurt or denigrate as a response. It was not expressed initially, except in its masochistic form (i.e. instead of being projected out towards others, its emotional energy was re-directed back to the self), when Lore felt victimized by others, or their internalised representations (e.g. her cousin's voice, memories of bullying at school). It is important to note that at times, Lore was bullied in this way by others

in the past and present. At other time, it was an internal voice that became activated and controlled her perception of others' intentions towards or views about her. As an internal voice, it first was heard by Lore as an attack on her competencies: that she was fundamentally deficient, and that she would never be able to achieve her goals, in work or love. She avoided these feelings fairly quickly by turning to positive self- (or other) statements and work-related activity, or refocusing on perfecting her appearance. As this voice emerged more, she was able to own its source within herself and work toward understanding its origins. The Bully occurred within dialogue involving voicings by *Child* and *Independent Adult* (*IndA*) as well. Initial levels of assimilation will be described as part of **this voice** set, as a later part of Lore's developing acceptance of *IF* involved a recognition of its separate existence from *Bully*, and part of her acceptance of *Bully* involved recognition of the frustration of her personal needs lying at its core.

6. 4. 2 Assimilation summary across sessions

Seventy-three segments were presented by MR (the therapist –first rater) for assimilation analysis. Either one of both of the *IF – ACE* voices were believed present in each segment. After a second round of comparing ratings, and discussing verbal assimilation descriptions, consensus was achieved. Consensus included 83. 5 per cent where raters agreed on APES level, and 6. 8 per cent where they disagreed (i.e. disagreements in ratings reflected genuine differences in how raters perceived the voices and their relation to the model), and 9. 6 per cent were considered unrateable for this voice set by the second rater (MG). These ratings across segments achieving consensus in chronological order are represented in Figure 6. 1 (the segments determined as unrateable by at least one rater have been extracted from this series).

ACE's strength was evidenced by the consistent rating of *IF* at levels 0 or 1 during the early phase of therapy (i.e. it was warded off as intrusive and unwanted, or ego-alien). Only in session 5 was Lore's *IF* voice owned as hers. As she became aware of its identity as part of her own *self* (Level 2), it still provoked uncertainty and guilt, and Lore continued to be dominated by *ACE*.

Session 7 was a pivotal session where *IF* emergence approached Level 3, first vacillating between Levels 1, 2 and 3. It appeared that as Lore was willing to bring *IF* into direct conflict with her *ACE* voice, she regressed at moments and became apologetic for the strength of feeling she could own, concerned how it might affect her relationship with her therapist. As this fear was gently confronted, Lore began to recognise the value of expressing her feelings and concerns, so that she could look at them more closely as signals to think before automatically responding with bright or compliant approval for others and their plans. Her feelings of dissatisfaction were no longer to be avoided, but could be entertained. As movement occurred within another conflict, and Lore's *Child* voice loosened its dominant hold as a defense against losing closeness to others and avoiding separateness, Lore was enabled to express her desire to think for herself, and *IF's* feeling dissatisfaction did not have to remain an unhappy entrapment into depression, or dreary resignation.

This shifting stance between *IF* and *ACE* continued until sessions 12 and 13, when Lore began to express more insight and meaning into the relationship between these two voices (Level 4) and attempt solutions within interpersonal scenarios that previously relied on either her ability to offer mask-like cheerful and efficient responses or evoked negative instincts or feelings. These became occasions where she could attempt to alter or test out different ways to use *IF*-related information in different encounters. She was just beginning to apply her learning to the re-establishing of social relationships following the break-up of her engagement with her fiancé, and negotiating a less stressful work environment when her therapy contract ended. This included her decision-making regarding the state of depression she was still experiencing at the end of this time. She still struggled between her old tendency to be optimistic and cheerful (ACE), rather than remain in the experience of her depressed feeling (IF) when speaking about her fiancé (Level 3), but this was felt by her therapist to be an appropriate way to manage her state of depression at this time. She could face the separation with her therapist and state her ambivalence, and also realise that she had both inner and outer resources to continue to handle this at this time.

Bully's emergence as an active, outer-directed voice of aggressive, critical energy (Levels 0 – 1) remained isolated and somewhat confusing if not mysterious (e.g. frenzied attacks on objects, or hurtling anger at people), and at first Lore could only

talk about these incidents from an objectified stance taken by *ACE* or *Child* (i.e. however she spoke as if she was talking about someone else). In its inner-directed form, invoking self-negation or blame for failure or incompetence, *Bully* appeared more regularly, even though it was usually opposed by *ACE* (Level 1). Lore was only able to identify this voice in self and others with some consistency (Level 2) at session 7, and during the last phase of her therapy, she was able to speak from and reflect on her *Bully* voice at early Level 3. It was only at this time that both Lore's *ACE*, and *Child* voices had softened enough to permit a more direct connection with more primitive impulses of frustrated and hostile anger. She was able to engage in early reflection about the reasons for her own aggressive impulses and her ability to cast a critical evaluative tone on other's behaviour without fear of her own fear-laden *Child* or guilt-inducing *ACE*.

The pattern of assimilation ratings across segments containing these voices across sessions 1 – 17 are given in Figure 6. 1 below.

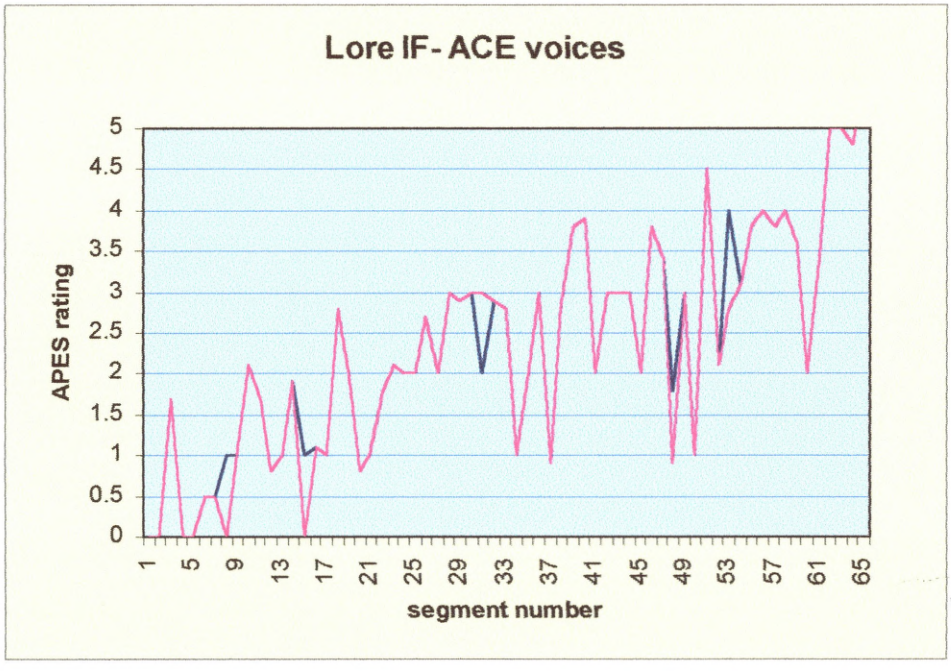

Figure 6. 1 Consensus APES ratings for consecutive therapy segments related to *IF – ACE* voices (Lore). [Pink trace = agreed ratings; when disagreements in ratings, pink trace = MR and blue trace = MG]

6. 4. 3 Key processes in *IF* assimilation and *ACE* modification

A more precise inspection of the voices and verbal assimilation descriptions composing the APES ratings over time indicated that smaller processes were occurring, which represented a blend of movements occurring as the emergent voices became more present, accessible, and known, and the dominant voice became modified in its quality and usage. Thus certain processes involved inner shifts in Lore's use of, understanding and reflection about her voices. Other important movements occurred as the therapist responded to these ongoing processes and used therapeutic interventions to help Lore develop certain kinds of awareness. Together, these processes as they related to movement in the assimilation or accommodation of Lore's voices are listed in Table 6.3 below. They were derived from the verbal assimilation descriptions accompanying each APES ratings, and examples are given which include these ratings and the related therapy segment.

Processes observed	APES
***ACE* is dominant and effective**	
1. ***ACE* defends self against emerging *IF*.**	**0 -1; early 2**
2. **Functions served by the dominant voice (*ACE*) begin to surface.**	**0 – 1**
***IF* encouraged to emerge**	
3. **Focus on sensations and feelings help develop *IF* awareness.**	**0 – 2**
4. **Others – or historic child – as examples of *IF* are viewed.**	**1 – 2**
5. **Dominant voice reacts to intrusions by emergent voice *(IF).***	**1.5 - late 1**
Exploring expressions of *IF* and reflecting on *ACE*	
6. ***IF* sustained for slightly longer periods.**	**1 – 2**
7. **Safe exploration of both dominant and emergent voices is encouraged.**	**1- 2**
8. **Limitations of dominant voice are recognised.**	**late 1-2**
9. ***IF* appears in new situations.**	**2**
Conflict approached and recognised	
10. **Contrasts between *IF-ACE* feelings and values are made.**	**2 – 3**
12. ***ACE* and *IF* struggle with each other.**	**3**
14. ***ACE* dominance returns with new threats on occasion.**	**2 – 4**
***IF* joins community and new feelings owned**	
15. ***IF* becomes more trusted.**	**4**
16. **New understandings are applied to interpersonal situations.**	**3 – 5**
17. **New problematic voice emerges, opposed by accommodated *ACE*.**	**1 – 2**
18. **Listening to *IF* and gaining ability to contain difficult feelings.**	**4 – 5**

Table 6.3 List of specific processes with assimilation of *IF* into Lore's *self* community

6. 4. 3. 1 *ACE* is dominant and effective

1. *ACE* defends against emergent *IF*.

Lore's *ACE* voice dominated her dialogue at the beginning of therapy. Lore liked her qualities; and identified strongly with them and their implicit values. Over the first few sessions, it became apparent that the smooth and pleasant ACE was also part of her projected image of a successful career woman. Initially Lore denied the relevance of permitting a more variable way of responding or awareness of her own impulses reflecting personally sensitive, body-based or 'gut' responses to responses to situations or her own needs. Her *ACE* values also impacted on how she felt about owning her pain episodes.

S 1 - 603 APES = 0.8 ACE states that moaning over body state is counter to central values of being cheery and positive.
[CL] I don't think it is okay to moan about it. I don't moan about my pain. I try to keep it to myself, as much as possible. I don't want it to bother others……it's bad enough it bothers me. I don't like to spend time talking about my problems to other people anyway; I like to think on positive things, you know, be cheery.

S 2 -014 APES =1 ACE dominates in the face of experience of fear, and pain follows. IF is intrusive but unrecognised except as barely skimmed topic, and avoided.
Comes in bright and cheerful but launches into tale of recent anxiety that belies her presentation of unruffled contentment.
[CL] Fine, yes. (*very cheery* voice)
[T] You look very bright and cheerful.
[CL] Yes I feel better, mmm hmm.
[T]What's been happening?
[CL] Hm……nothing out of the ordinary, just an ordinary, but I don't feel that I've been quite as bad this week…….. but it did flare up yesterday because I had a dental appointment and I often find when I get anxious about the dentist, it makes it quite….at work….because I was going after work. I felt then I was a bit, you know…(*makes grimace*)……

With some prompting, Lore began to reflect on and objectify her attitudes that were consonant with her *ACE* voice early in her work. These reflected important values for her, and were easily elicited. Similarly, many of those behaviours and attributes detested by *ACE* and which were part of *IF's* attributes could be perceived as opposite to *ACE*. For example, emotional expression, outside of a continually smiling and pleasant approach to others, was considered unprofessional, and undesirable in social situations in general. This objectification and identification of attributes was seen as a first step in separating from a total identification with her dominant voice, and a recognition of the qualities that made up her emergent *IF*. Any experiences of revealing these inner events was similar to how she felt about experiencing pain: it felt threatening to her social relationships.

S1-023 APES = 0; *ACE* values take over during emergence of *IF* and pain (e.g. her concerns, in how she presents to therapist – *e.g. everything is very nice*).
Lore is speaking about attending her best friend's wedding; on the day she was struck with a bad episode of pain, and also feelings of loss which surprised her.
[CL] Yes! It wasn't too bad. I wouldn't let it get in the way, you know, but I was....worried it would get bad and it would ruin everything. But I was able to go on okay.....I just feel less....pretty, and worry I won't be able to do the things I needed to do, as maid of honour. I feel awful, I think I must look awful, and you know, you want to look good, when you are in the wedding party! It was such a special day, and I wanted to do well for my friend.....but the wedding was really very nice, it was a very nice day, after all (ends, sitting back, as if tension has been suddenly relieved; smiling and musing into the distance).

Lore doubted the authority of her own feelings; they turned her into an occasional *screamer* and *chair-kicker* and sometimes bade her to *be lazy*, even as an adult. In the passage below, she offered another reason why. Frequently Lore felt implicitly and unfavourably compared to her cousin, although when she tried to find out if others intended (or were aware of making) this comparison, they told her she was being silly, and therefore she doubted her instinctive impressions.

S 2-741 APES = late 1 More ownership of feelings (in family relations), but still questions them.
[T] ..... you imagine that people are comparing you.
[CL] Mmm hmm.
[T] And when they said that to you (*you should be happy with the job you have*), how did you feel?
[CL] Frustrated really but nobody can actually see how I'm feeling, you know.
[T] Do you doubt yourself at all?
[CL] A bit, I do that quite a lot nowadays!
[T] So .....although right now you're saying, no I can see why they're doing.... and it's not cause it's not real .....[ ] .....but when it actually happened, you think oh, maybe I am making this up, why am I complaining?
[CL] I think it's something .....in myself, that isn't right, you know.
[T] Again, you're making a fuss..... about something you shouldn't be making a fuss about.....
[CL] That's right, mm hmm.

Another, more secondary manifestation of *ACE* involved Lore's dedication to efficiency and pride in her council work, housework or management of affairs more generally. She expressed the belief that *she must always be dependable and efficient*, and this appeared to keep her routed towards her achievement goals, as well as pleasing others.

S 3-014 APES = 1 Expression of *IF* (illness symptoms and irritability) which demand attention, but *ACE* dominates response to this event.
[CL] I had to stay off work Tuesday as well, which is unlike me.
[T] So, what is that like.....to not be like you, to miss work.....
[CL] Quite.....it's quite.....you feel very guilty for not being at work. Being off sick. You feel...you are letting your side down, you know. Not that you are, but...it's just.....somehow, I am....quite a perfectionist. (*pause*) So I don't like being off.
[T] You get worried, that you are losing....something important...
[CL] Yes, and....that I am letting the team down.
[T] Try to [watch Lore] think these things from a distance. What would you say about her?
[CL] Ah,.....em.....she must be quite ill because she's never off anyway.....it must be genuine.

[T] It *must* be genuine!
[CL] It is the way I feel anyway....I don't like being off, I have to be really ill in order to let myself off. It takes a lot.

2. Functions served by dominant *ACE* begin to surface.

Embracing positive attitudes kept Lore from experiencing disappointment, modulate painful events, and distance herself from feelings more overwhelming or darker moods, which lurked at deeper levels within herself. Lore herself was aware that her attempts to perfect her appearance and look as smart as possible was her way of controlling her feelings (which could be messy and distasteful for others) and managing the impression she made on others, which was a relatively constant implicit if not stated value. The 'mask' provided by *ACE* was later associated to episodes of bullying she received as a teen-ager, when a group of boys repeatedly told her how ugly she was, which resulted in Lore's withdrawal from social events. Lore's family were the primary sources of feedback about her attractiveness, and their messages were mixed: although her mother and father and auntie praised her, her cousin and grandmother indicated her social and personal limitations.

Evidence for *ACE's* defending against more intolerable experiences within herself came with its stubbornness; at times the therapist felt as if she were *refusing* the relevance of any other part of her personality.

S 3 - 403 APES = 0 Therapist–led; while *IF* can be present at times in expressing dissatisfaction, when therapist interprets and challenges, and asks L to reflect, L doesn't acknowledge existence of alternative voice.
[T] It's like...(*slowly*)....[*mimicking L's recent insistence*] If I really think about this from another perspective, I might stop caring! Become lazy! It's like.....when you were talking just now, Lore.....over here it feels like most of the time, you allow just one side of things to get spoken. And then occasionally, you acknowledge you are annoyed, or that you may be taken advantage of, because you are so dedicated and work industriously.....but you can't give into those feelings very much, because they might ....do you harm.....put you in jeopardy of losing other's good opinion of you.....you are not allowed to be annoyed, or have any grievances....
[CL] Uh-huh.
[T] It would seem, you can't ...care so much about everything though, that there is a part of you that has the capacity *not to care so much* .....and care more about your own feelings..... [ ] ...I wonder where that part of you is?
[CL] I don't know. At least, it isn't in the main frame. I don't think.....she exists. I like being conscientious.....and cheerful.
[T] Maybe she comes out just a wee bit, when you have fantasies that others see you as slipping, not being so conscientious....skiving off because you are out for a day.....
[CL] Maybe. I can't imagine doing that.

6. 4. 3. 2 *IF* encouraged to emerge

3. Focus on sensations and feelings help develop *IF* awareness.

The therapist noted that *ACE's* rigidity offered Lore a security against needing to contend with any other feelings requiring a different response on occasion. At times her reliance on manifesting her cheerful and efficient disposition was a strain, as it required more energy than Lore's actual emotional state could support. The first steps towards seeing the limitations of this voice came with asking Lore to more sensitively perceive her physical and emotional state at specific moments: in session, and in remembering recent events in her narrative. She was responsive to these invitations, and became more aware of its characteristic energy and the strain *ACE* produced. *ACE* became perceived as a high-energy state, by both Lore and her therapist, with hair-trigger responsiveness, which *pushed* Lore from the inside, to avoid distress of all kinds.

S 5-053 APES = 2 Can admit to *IF* feelings, but still a bit embarrassed.
L has just found out, she didn't get a job she wanted badly.
[T] Do you feel any envy?
[Cl] Uh.....well, yes, I do. (*some embarrassment expressed in face*)
[T] That makes sense, doesn't it? It would be a natural feeling, when someone else gets something that you want and then you can't get it too. Any fantasies about her?
[Cl] No, not really. I just know she was slightly better than I was.

S 5-202 APES = 2 Therapist – led, but agreed and elaborated by L admission that pain is associated with body expressing needs, acknowledges chronic avoidance.
[T] When your body hurts, it is asking for something.....
[Cl] Yeah. It is crying out.
[T] But you don't like to pay attention to it.
[Cl] No. It's.....there all the time. So I think, I just sort of....forget about it. And being busy, that helps.

4. Others- or historic child – as examples of *IF* are reviewed.

In early sessions, Lore became willing to talk about negative or difficult experiences she had, but could only do so in ways that were controlled and punctuated by an *ACE* framework. Other people could feel and express impulsive emotions or spontaneous opinions, and this appeared to offer some satisfaction to Lore, either by giving her opportunity to contrast her containment now, or as examples in which she could offer some compassion for difficult *IF* expressions. One involved a historical event of her own, although it was mixed by an *ACE* criticism of her behaviour.

S 2-055 APES = 1.5 *IF* permitted expression and, offered understanding during reflection on historical event; but dominant *ACE* also embarrassed by *IF*.

L is talking about a trip to the dentist as a child, and relating it to her current fear of dentist.

[CL] Mmm. I just recall I was going to be getting a filling..... and I was only about five..... and I just think that I didn't like it..... and I, I, I..... I think at one stage my mother refused to take me, so my Dad always took me. I think she was embarrassed by the way, I used to scream and that, you know. So I think it's just like a thing since then, it's kept me, you know.

[T] Do you actually remember the incident yourself... or have you been told about it?

[CL] I can slightly remember it, you know. [ ] I think I was getting an injection and another thing was I had a very bad experience with the gas, shoved the mask in my face, I remember that.....

[T] He was putting you under....

[CL] Yes, ahh ha. I was going to get teeth extracted. [ ] And that was at the time when they didn't really..... I think that's been stopped now so I think now they do it, they give them an injection, but I was just the gas mask was shoved in my face (*nervous laugh*) and ever since them, I've had this fear, you know.

[T] Of course, being ....your mouth feeling like you're being ...

[CL] Yes and it's horrible, it's not the nicest sort of feeling. You know and I was very sick when I came out of it as well.

[T] Yes.

[CL] So I think that's been in my mind. (*sounds less nervous, more vulnerable as if memory is indeed present for her*)

[T] Had you been prepared for that experience, do you think?

[CL] I don't think so. [ ]

[T] Okay. ....after that mmm you were scared and you screamed and so your Mum didn't even want to take you.

[Cl] No. I think she felt quite mortified, so Dad took me and I was great with him.

[T] It was better with Dad .....

[Cl] I think he was calmer, you know that he didn't lose his patience with me.

[T] But your Mum would have?

[Cl] Yes, ahh ha.

[T] She had a problem..... feeling embarrassed.....

[Cl] Uh-huh, Because I used to be.....I really used to be terrible, I used to kick the chair and I was just so uncomfortable.

Later, Lore admitted she also felt embarrassed by her behaviour as a child, and now by her fear of dentists as an adult.

S 2- 150 APES = 1.7 Goes further into split between embarrassed *ACE* and screaming *IF as* child, and the difficulty of owning the latter .

[Cl] Probably because it's really, when you think about it, it was a silly thing I was frightened over. You know, I used to be terrified of the wee you know the little drill but when I see it now, it's like, what was I complaining about... but when you're very young, you've got a different perception of things.

[T] Sure.

[Cl] I still feel quite embarrassed about it, but ..(*slight laugh*)

[T] So, there's a little bit of your Mum in you in that way?

[Cl] (*thinks a minute*) Yes, ahh ha.

[T] Your Mum, you're saying, she got embarrassed and she's mortified ahh and she lost her patience.

[Cl] Mmm hmm.

[T] Ahh it's too difficult to be *just* understanding..... and you're like that a little bit too.

[Cl] Yes ahh ha.

[T] And so..... mmm..... what's that like..... to have two parts..... or two places in you, one which just understands! that young mind was, was terrified! and the other that was just mortified to think that Lore would carry on so?

[Cl] Mm-hmm.

[T] .....and still does, in a small way.

[Cl] It's quite difficult really to..... mm (pauses). I think it's probably because I think, what would people think, if it was me, now, taking a child to a dentist? My God, you know, what's the carry on? I think I would just be quite embarrassed myself, badly, like my mother was.

5. Dominant voice reacts to intrusions by emergent voice *(IF).*

When impulsive feelings did occur, they tended to manifest initially in quickly suppressed reactions, or short burst of affective behaviour later encapsulated by Lore as shameful behaviours. It was difficult for her to talk about them.

ACE usually found a way to re-exert its control over Lore's experience when she began to explore these intrusions or states indicative of another voice speaking from within. In an early session where family relationships were being explored, she was directly asked if there were any concerns she was having in her relationship with her fiancé. Although this was part of a review examining the status of her current interpersonal relationships, her therapist also considered that her prior, consistently positive descriptions had been *too* glossy; they were over-generalized and sometimes delivered by Lore as if she were speaking from a distance. Now she could let herself express her disappointed needs within this relationship, but quickly reverted back to *ACE*'s perspective about this.

S 2 - 1098 APES = 1.6 Bridges on acknowledging negative, unsettled feelings, but avoids acknowledgement of simple need to have more contact and feeling frustrated; instead blames self for response and uses work stress rationale. Interpreted as confusion over true nature of feelings, but beginning to express conflict. Note that her exploratory tone is hesitant, tentative; (but still *ACE* perspective)
[T] Have there been any problems in your relationship?
[Cl] (*pause*) (*starts slowly, carefully*) Sometimes I can get ..... somewhat.....moody. Sometimes I feel myself.....going....quite ....quiet.
[T] What's..... not going right, what are you missing out on?
[CL] It's hard to say really. Em.....I sometimes think it reflects on my work. If I've had quite a bad day at work, some people have been not annoying me but you know, I think it comes home to your home life. I think if you've had a lot of bother at work, it can be, you know. Cause I work in not a stressful environment but you know when you're working for a director it's quite mentally tiring. You know when you go home at night you just feel a bit..... washed out.
[T] Tired and ...
[Cl] And.....a bit irritable.
[T] And you're irritable .....because you've been too stressed .....and you need.....(*gently*)
[Cl] I would say, you see, I don't live with my fiancé and sometimes I feel I don't really see him enough and that gets me.
[T] Sure..... And you're making plans .....but they're fairly future.
[Cl] Yes. Ah ha, there's nothing at the moment. Nothing to look forward to.
[T] Yes. That's rough. Does he know how you feel?
[Cl] I think so, I think I've sort of explained to him, you know.... but I think..... it's just the same story, things will change when we're ready. There's no point in changing the goals now. We've agreed two years so that's what we want to sort of do, you know.
[T] But you don't get to see him enough and you'd like to see him more.
[Cl] I'd kind of like to see him more; but his job as well, it's very awkward at nights, you know. Sometimes it's, he's not home until later, you know, it can be and some nights I just want to see him, you know, a bit down, so I just want...

Later, Lore was more able to talk about other intrusions that provided more powerful experiences. For the therapist, the intensity in some examples of *IF* intrusion indicated the possibility that these were expressions of a long- repressed voice. The fact that she could talk about them at all at this point indicated that some acceptance - enough to view herself during these intrusions - was occurring.

S 8 - 680 APES = 1.6 Exploration of barely owned *IF* voice; but emerges in real description, although still reported from *ACE* perspective, and denigrated, but L gives reasons for *IF* feelings.
L describes an argument with her mother.
[T] And you are shouting back, after listening to all this....(*shouting back at your mum who is yelling at you in frustration*)
[Cl] Quite.....it's not.....it feels....em..awful, because it's *not me*. But it's just something that, ah, clicks in my brain, and I've got...to retaliate.
[T] Part of you takes over, when you are being yelled at, and retaliates....
[Cl] Yeah..... yeah.
[T] Tell me more about that part of you.....now you don't like her very much, that part of you.....but what it is like to have her take over.....
[Cl] Uhm....I'd say she is very aggressive. (*curt, judgemental voice*). Uh-hm.
[T] Aggressive? (*surprised*) You mentioned this before.....in another way.....that you see her as, aggressive. Like how, what is happening ....
[Cl] Just, ah, when.....how would you say.....very....fire-ry. Possibly, not...forcing things, but doing damage.....damage because of herself.....you know.
[T] Uh-huh. In what way?
[Cl] Possibly.....pulliing her hair, or.....really getting quite.....it's like, someone else, takes over.
[T] Yeah. She gets fiery, can do damage to her hair.....be disruptive.....even if....she didn't throw something, she would hurt....+
[Cl] + something might just happen, yeah, she might.....scratch herself, or...just. you know...
[T] Really angry, needs to hurt something.....and she is shouting like your mum does.....
[Cl] It's different. It is more like a .....scream....it is a scream, I think it is more....forceful than.....you know, it is a way of retaliating.....trying to get back...

This was one of the first examples in which Lore was able to describe a frenzied feeling state, which became encapsulated as a distinct voice, the *Bully.* However, even less stormier moods or feelings offered by *IF* appeared to be experienced as alienated from her dominant voice, who commented that she should ignore and suppress any problematic feelings (e.g. restless unhappiness, anger, jealousy). Other examples occurred when feelings of horror, terror, or 'freezing,' provoked an avoidant response or inhibited Lore from moving forward, as in making appointments with the dentist even when she was in pain.

6. 4. 3. 3 Exploring expressions of *IF* and reflecting on *ACE*

6. *IF* sustained for slightly longer periods.

Other times, a more generalised moodiness appeared, which indicated *IF*'s attempt to be heard and that it was still mostly warded off. Initially these had been rated at APES levels 0 – 1, where this expression of diffuse unease was believed to

represent a warding off of *IF*. Lore owned responsibility for these moods but still found it difficult to give them a real and informative place in her experience. When pressed, she often associated her moody state to her symptoms of pain or her concern that it would occur, and ruin everything she – as her *ACE* voice – had planned. Her therapist, at these moments, experienced Lore to be like a large restless creature, whose body was attempting to stretch and relax cramped muscles, tired from remaining in a caged or cramped position. Later on (i.e. around session 7 or 8), Lore began to wonder out loud what these moods meant, and whether something was *brewing inside* of her. She talked about *remaining* in these states of mind for longer; she appeared to be less anxious about them although they remained unpleasant experiences, she was no longer insistent on pushing herself out of them.

At the start of her work in therapy, Lore had maintained this diffuse awareness of – and avoidance towards – her feelings. Her first attempts to entertain them more completely brought up fears of increased and generalised vulnerability, and the possibility that she would see horrible things about herself.

S 7 - 300 APES = 1 Note also that *IF* has during bulk of session been speaking and given support, and now in this retrospective event gets *trapped.*
L is talking about a mood she has been in for the past two days. She has related it to her time of the month, but also is not dismissing it through this attribution. She wants to describe it.
[CL] It is a negative....swirling....kind of blackness, swarming....down on me at times. [ ] It is something I tend to keep....within myself.

7. Safe exploration of both dominant and emergent voices is encouraged

The therapist attempted to offer containment for this process, by keeping regular boundaries around it and holding onto and helping Lore view how the qualities represented by each voice (e.g. *her industrious bright attitude, her emotional feelings*) offered examples of different kinds of strength. The latter goal was attempted by highlighting the voices of their contrasts whenever they occurred, even when one voice appeared at a different point in the session. Given a containing place to explore her feelings and their associations, Lore was able to take up an invitation to listen in to a more spontaneous and feeling part of herself. One of the earliest discoveries was that *ACE* responded by telling her she was self-centred by doing so. At other times, *ACE* returned a few minutes later, and brought feelings of guilt. Initially these had been identified in fantasies of fearing others perceiving her as lazy, uncaring or just bad; now Lore recognised she held these criticisms of others, herself.

S 5 - 295 APES = 2.5 Exploration of her two voices *ACE* and *IF*; sees conflict between them but can't resolve, and *IF* still dominant.
[T] What would that be like, for you to give into that part of you.....that wants to do things, like lie down...
[Cl] As I say, I get very..... sometimes.....I just.....want to.....lie down.....hm.....but I can't .....because.....things are going on.....you know (*looks tense*).
[T] Like.....your obligation to be *here* [*meaning; here in therapy*]....yet, you know, this is your time to do with whatever you want.....including make the decision not to come if you're not well, or say when you want to cut the session to end, to go home and rest....and on this particular night, your tum (*stomach; therapist puts protective hand on hers*) may want something different than to stay here.....
[Cl] But then, a part of me would feel bad about going.....leaving early, a session....that isn't.....it would just seem, that I would let you down...(*shrug*)....
[T] What would I think of you, do you think.....if you let yourself leave early?
[Cl] (*muses*) I think.....you would ....respect me!
[T] Part of you *knows* I would give you respect.....
[Cl] Uh-huh.
[T] But another part of you thinks.....
[Cl] It's just.....this sort of.....perfection, inside of me.....telling me, that I can't do what I want.....
[T] Everything topples down on you.....
[Cl] Yes.
[T] When you can't do things exactly.....so you get disappointed, because it can't *ever* be done exactly, all of the time....
[Cl] That would be impossible, yeah. I still.....punish myself, for not doing it though.

As a result, Lore became able to recognise her feelings more often, particularly those that represented 'gut instincts' about people or events. Thus, she became able to identify her *IF* voice and own it, more frequently.

8. Limitations of dominant voice are recognised

Around this time, Lore began to acknowledge the limitations of her *ACE* voice in helping her reach the very goals once equated with its values: to secure affection and approval. These comments were offered from the perspective of *Instinctive Feminine.*

S 5-415 APES = 2. 7 Lore considers that *ACE* is not all positive, but causes stress.
[T] So *your inner professional* [*ACE*] does take care of you too, in some ways, keeps you from not doing too much for others, perhaps....otherwise keeps your nose to the ground....she makes you feel good...
[Cl] Yes, uh-huh....but I also think she causes.....a lot of unnecessary stress.....Uh- huh.
[T] .....because she wants things to be done a particular way (*questioning*).....
[Cl] Because she worries if she'll get across the road at night, as well.....she worries about everything.....
[T] She is hyper.....anxious.....about things...
[Cl] She worries all the time.

When she was tired, however, she realised that she was neglecting herself and her own needs, and grew less willing to rely on *ACE.* She could begin to appreciate

that her *ACE* voice was not healthy for her (i.e. she could begin to identify the conflict between *ACE* and *IF*), she felt stuck on how to change this.

S5 - 460 APES = late 2 She agrees with conflict between *ACE* and *IF* as stated by therapist, but feels stuck on how to change, and is dominated still by *ACE*.
[T] I get the feeling ……..your [inner] professional doesn't really like your body much….
[Cl] No. Cause. Because I don't…..I can't think of a time when I've let my body be totally laid back, relaxed. There is this perfectionist …….. in me, that won't let me be relaxed……
[T] Keeps you working, worrying, criticizing you…..won't let you relax.
[Cl] The profectionist……. is there most of the time.
[T] And you like her, what she is……..but she won't let you relax….the price you pay…….I guess. And you need her, she does a lot for you……but maybe if you didn't have to be her all of the time…..you could let go of the worry for a while….
[Cl] Yes. I just can't see how to do that. There is something…..just stopping me.

At this point Lore could take the position of accepting instinctive and spontaneous feelings more consistently when they were expressed by others (e.g. anger, joy; the need for rest, a dislike and reluctance to go or do something) while her own dominant *ACE* still felt aggravated by the prospect of her doing the same. Her therapist felt these brief narratives about others reflected a shift within, as a way of articulating a focus on the still-repressed voice more safely by considering why it should be permitted expression. They gave the appearance that Lore was trying to work something out, or use others as models for how she herself might consider modifying her own views.

9. *IF* appears in new situations.

In a relatively early session, Lore was able to allow negative feeling about her cousin surface, and although she apologised for it, she was better able to own it *and* the fact that it conflicted with another value she held.

S 4-192 APES = late 2. Conflict is in evidence, but L permits a late 2/ early 3 reflection, and ambivalence in the same moment (underline is *IF*; bold is *ACE*)
L speaks bluntly about her reaction about her cousin, followed closely by apology
[T] (*summarises*) You know what she is like, and can have insight into why she acts this way…..
[Cl] I can't really stay in her company. I know that is quite awful to say. But I can't really….
[T] Here again you qualify your feelings – very understandable feelings – by saying, I shouldn't really feel this way……you have just given me very good reasons why you shouldn't like being around her at all……..
[Cl] I feel I kind of have to do it, because she is a blood relative……I haven't really spoken to her since, not really, and it is important to keep speaking to people…
[T] She is your blood relative, you want to keep good ties to your family….sure. But feeling the way you do…….. One of the things I am picking up is that you aren't sure it is okay to feel *all* of the things you feel. Like, dislike for your cousin, wanting to avoid her criticism ….*and* wanting to keep speaking to her as your blood relative at the same time….and you say, you feel both things.
[Cl] Yeah, that's right. She is a cousin……..but she won't be a….close cousin.

Later, she began to see other ways in which her dominant attitudes had conflicted with other experiencing. One domain in which Lore began to *sense in* to more

instinctive feeling centred on her experience of pain. Her descriptions also shifted from physical pain adjectives into more emotion-related or voice-like qualities (e.g. *clamped fists within her belly*). This shift became one basis for future exploration of feeling.

s11 –190+290 APES = 2→ 3 Able to tap into stomach sensations and give it psychological quality, and so 'reads' or moves into *IF* as associated incident, through its *feeling* and *imagery*.
[T] So what is going on in your stomach right now?
[CL] Its .....its like it.....is on edge. It's feeling tetchy. Not relaxed; something is feeling cramped.....it's like there is a barrier around it...
[T] Sounds like it is getting crowded in there.
[CL] It feels very busy.....
[T] Are you saying.....it is trying to be small? Something is ....trying to make it smaller?
[CL] Yes, that's right.
[T] I get a picture.....part of you all crowded in on itself in your middle, trying to be unobtrusive...small...
[CL] (*laughs*)
[T] I guess that is a funny image.
[CL] I'll tell you what else is funny.....I got this haircut yesterday....and I went in to work, and the director came right up and said, he doesn't like it! He says, he doesn't like ladies with short hair....only with long hair....that, kind a.....I thought, who is he, to sort of.....I mean, what business is it of the *director*.....[ ] You know, it's not as if he is anything to look at, himself. Because he isn't. He is....ah....I couldn't rate him as....attractive.....
[T] I wonder if there is something in that.
[CL] Well maybe. Because he isn't good looking, who in the hell is he to tell me my hair is unattractive?
[[T]] He is picking on you.....I wonder why he thinks he can do this.....
[CL] Yeah. Well, I'm just thinking about this now. I think he may pick on me, because I am the youngest, and he knows I won't retaliate.....some people would, there.

6. 4. 3. 4 Conflict approached and recognised

10. Contrasts between *IF-ACE* feelings and values are made

Lore experienced more variation within herself, and also with her feeling response to events or decisions: what might be important and interesting in one moment might lose its salience in the next; what she had chosen to do for an activity might not be what she actually felt like doing when the time came. Eventually, this movement translated into the domain in which *ACE* held a particular stronghold: her work performance. Making this link between the need for more balance between inner voices in dictating her activity and goals brought a sudden sense of relief.

Therapeutic interventions at this point continued to aim at helping Lore focus on her feelings, and to permit her to *think* in relation to feeling them, without criticism.

S 8 – 112 APES = late 2 / early 3 Directly contrasts voices in problematic experience; *ACE* stronger but no longer dominating so much.

[T] You know, an image has come to mind....it may not be relevant here, but I'll ask you: I am aware that your two weeks doing an energizing job, which you loved, are also coming to an end tomorrow. The image is like, Cinderella leaving the ball, and realising that after midnight she goes back to rags and wicked stepsisters.....
[CL] (*laughs*) Yeah! That is just what it is like! (*laughs again*) Back into....the....slightly changing....roles again. (*voice drops*)
Silence
[T] So you go back, but it feels to me that there is something not being said about what it is like, going back...
[CL] It feels depressing. Don't get me wrong, I like my job and that (*reassures with anxiety*)...but I will miss this job. It doesn't challenge me, the way this other job did. I liked it better (*voice is depressed again*)

Lore's ability to tolerate confusion and ambivalence was growing. By the time its emergence had reached the latter part of Level 2, *IF* occurred more freely and spontaneously, as an evaluative response to events, although with more difficult or mixed feelings at first. Lore could now more easily describe these feelings or sensations as a starting point for exploring her own reactions. Even in very sensitive areas, where strong feelings of fear or anger arose, she became able to identify more personal feelings.

S 9 -260 APES = early 3 Both voices acknowledged and speak. More comfortable with ambivalence, but ACE is still stronger.
[T] Okay, so you have had this disappointment. leaving you feeling angry and disappointed, and on the brink of breaking off your relationship ....but then you remind yourself, how good he is for you, to you.....and just before, you told me about how a break-up affected you.....although earlier it was your boyfriend that broke up with you.....so it was different .....
[CL] No, but I .....yes, I think it might be the same, in other ways....what it would feel like to break up. I wasn't serious about it, it was just.....you know, a fleeting thought.
[T] Sure, that is what I heard. But it feels like part of you is a .....frustrated voice, ready to say, this isn't what I want, before.... a stronger part of you.... steps in and says, no, don't you dare think that.....you don't want to be lonely, left alone....
[CL] That's right. That's just the way it is....I do think that, and it is like having two different.....(*gropes for a word*)
[T] .....parts? Voices inside?
[CL] Yeah. They are both there.
[T] But the part that says, oh don't put up with this, you could do better feels scary to you.....the rest of you....
[CL] Yeah, uh-huh. I would be afraid to do that. But I'll admit, I do think about it.
[T] I get the feeling, these thoughts have grown stronger recently.
[CL] Well, I am getting annoyed more often. I just.....it bothers me, that my fiancé doesn't seem to have much initiative. He is willing to go along with things....

Lore was experiencing new flexibility in her responses, and expressed *IF* responses with less reactive response from *ACE*. She also saw how her *ACE* voice had become a persona (i.e. manner of self-presentation to others) and had influenced how others perceived her. In a rare moment during an earlier session, *IF* gave expression to this view of herself, and its consequences.

S 7 -500 APES = 3 Uses understanding of how *ACE* dominance leads to neglect (by self *and* others) of her own needs.

L is talking about her depressed co-worker, collectively acknowledged to have problems. Others offered concern about co-worker's impact on other office staff, but not on her.
[T] Why do you think, no one ever asked you about it?
[CL] I think it was because everyone expects me to cope. Because I do.
[T] That's.....a problem then.....with always being so cheerful.....efficient...
[CL] Yep.

More contrasts between these two voices occurred over time. Lore became able to comment on either voice within, from the perspective of the other more flexibly. The segment below is an example of an ambivalence marker, stating incompatible goals, revealing the back and forth nature of embodying this conflict.

S 7 – 115 APES = 3 *ACE* losing dominance; speaking less and *IF* equally present, and commenting on *ACE*.
[T] So you are okay with what you are feeling, grumpy and disappointed and frustrated.....even though they are not unpleasant.
[CL] Yes, I'd say so....(*equivocal tone for a minute then steadies*)....I feel like I'm...uh....*imprisoned* in my work...cause I can't get to do what I want to be able...to do.
[T] And yet, there is still some concern, that you show yourself well at work, even though you are not happy there.....
[CL] Hm.
[T] And you.....
[CL] That's how I try to handle things, most of the time; like just laugh, brush it off. But it gets harder to do. I find myself spending more time thinking about how envious I am of my friends, who are getting new houses, new jobs.....

12. *ACE* and *IF* struggle with each other

Lore achieved recognition of her conflict as she was able to alternate between her two voices (APES Level 3) and embody their points of view with a sense of real (but less anxious) conflict, even if she remained stuck or unsure how to proceed.

S 9 - 220 APES = 3 Both *ACE* (BOLD text: nice understanding girlfriend, always looking on bright side) and *IF* (italicized) have expression here.
L has just admitted feeling some emotional pain, and begun to identify feelings arising, but without object.
[T] Is there anything else occurring right now....anything.... that might tap into feelings of pain or..... *I am sick of this*.....I feel jealous or competitive.....reactions that need recognition.....
[CL] There is one thing that happened two days ago. It isn't a big thing, just....annoyed me. My fiancé rang up, and told me that he had lost commission money .....you know, he is a travel agent and his income depends on commissions....he gets a salary but it isn't very much. *I wish he would get a different job.....or with a different company, than the one he is with.....but he isn't very good with money anyway.....*
[T] You are disappointed in him, what he has done.....even though you have told me before, you like being the chief breadwinner, and in charge of money....
[CL] (*gimaces*) **Well, you know.....It isn't really his fault,** *but I do get annoyed. He doesn't seem to care! I would never let my company treat me like they treat him! But he just goes along.....he doesn't have much ambition, and sometimes.... (looks the most annoyed and bothered she ever has in relation to talking about fiancé). I was pretty annoyed when we talked....***didn't say much and then hung up,** *and thought, I could do better than this!*
[T] You could be with someone who was better .....more responsible.....
[CL] *Yes! (looks strongly at me) I think that sometimes.* **I mean, I do love him,** but *sometimes I get tired*.....I realise he isn't very grown up. *I do think about dumping him sometimes*.....**but then I think about how good he is to me, he really does show that he cares.....John is like me in so many ways; he wants a secure relationship and**

understands why I worry about things.....gives me support to do what I want. He just isn't ambitious, like I am! (***smiles brightly***)

Her *IF* voice even offered humour on occasions in reflecting on *ACE.*

S 11-021 APES = 3 *IF* speaks its complaints, offers realistic view of what it feels like to exist in situation, then uses gentle humour to mock *ACE* stance and point out its limitations. Ends by making plans for change.
L is talking about her co-worker, who criticizes L's locum (replacing her at) work.
[CL] I mean, there is always....an.....undertone.....I never quite do things as good as anyone else, according to her....but of course, when they do *my* job, it is okay! And what I do, isn't the same as what anyone else has to do! (*a little sarcasm, but without inhibition*) Mind you, I can deal with that.....it isn't as important as when she is full-blown.....when she brings her problems to work, in a mood, and we all suffer. I don't think that is very professional, but that's just me.
[T] She makes it difficult for the rest of you to have a pleasant day.
[CL] It is very difficult to think, or speak, or anything! (*sarcasm stronger*) It doesn't affect me out of work, I'm not socially friendly with these people....just at work. And my stomach's getting better now....I'll keep an eye on it (*sounds positive*).....and see when it returns and how it goes.....in the meanwhile, I'll tr-y to keep *optimistic! (voice offers sing-song at end, then L laughs a long, melodious laugh; she is poking fun at herself).*
[T] Ah, yes..... that is what sometimes gets you into trouble.
[CL] Yes it can. It is...sometimes....the downside...of being cheerful.
[T] It keeps you okay for a while....then wears thin, and leaves you....depressed.
[CL] That's it. So, I am keeping my eye for jobs, in the paper.

14. *ACE* dominance returns with new threats on occasion.

Letting go of ACE was at times a relief, but it also opened up a new source of anxiety, repressed while ACE was dominant. Earlier, Lore became gradually aware that relinquishing her *ACE* voice brought her closer to increased feelings of vulnerability; risking dislike or displeasure in others, and painful feelings in herself. As she was able to embody and reflect on this inner conflict, occasionally she reverted back to a state of *ACE* dominance. In the example below, Lore herself can reflect on a return to a state of confusion, following an intense moment of vulnerability, which led to a take-over of control by *ACE.*

S 10 -130 APES – 1.5 →2 Although regains *IF* voice as she goes on, initially L responds strongly with *ACE* when she eases her behavioural restrictions and this results in potentially negative comment on her appearance and self-control.
[CL] My stomach's been okay. I was feeling some pain earlier in the week because I started a new diet on Sunday....but the foods I was eating made my stomach all bloat-ey. So I stopped and went back to my regular foods and now I feel fine.
[T] Why did you start a new diet?
[CL] Oh, on the weekend my dad said something about me getting fat. And that put me straight into a panic about my weight. I know it was silly, but I got worried, maybe I was gaining weight....and I worried about it. It was silly. John told me I was over-reacting.
[T] What happened?
[CL] I was sitting in the living room, with John on Saturday afternoon. We were just sitting here.....laughing about something.....I was eating a packet of crisps. My dad walked through the room, and he said to me.....you better watch it, you'll start getting fat! I was only eating a small packet, you know, the (*names money sum*) size! Really! It made me angry when he said that. I didn't think it was fair. But later, I thought, maybe I am gaining weight. You know, that is .....why he said that.

Just past the mid-point of her therapy, interpersonal events in which Lore felt under attack by others became a focus for her work with *Instinctive Feminine.* Although these were not entirely new events, in some way they *felt* new to Lore, as she now permitted herself to perceive and respond from this voice. Misperception by and criticism from others necessitated a sifting through feelings of vulnerability as well as reconnecting with the original motives behind *ACE:* to show others the quality of her care and efforts. Although processing these feelings brought pain, it was manageable.

S 10 – 790 APES = 2 Further work brings up depressed and isolated feeling underneath feeling of being misunderstood or wronged. Closer to recognising these feelings as own.
[CL] I don't want people to think that about me.....like I don't care about my job, or them. I care what my bosses....and everyone in the office....thinks about me....I don't do things to upset them. That's where I care the most. I really try my best, I am always trying my best. (*looks like an innocent, confused why others want to blame*).
[T] It is hard, when you are here, trying so hard, to understand why others don't see this....(*softly*)
[CL] Yes....(*twisted look on face, she is barely holding back tears)* I do try to understand.....
[T] Ah, but you do. You often talk about the things affecting people, why they yell or criticize you. But understanding is in your head, and your hurt is somewhere else. And it leaves you.....feeling cut off from others.....
[CL] Yes. Yes. That's when I feel alone, inside.

6. 4. 3. 5 *IF* joins community and new feelings owned

15. *IF* becomes more trusted

Even later, Lore's experience of instinctive impulses became more recognised as part of her and *relied upon* as a source of information offered. Once she could own these feelings and see how they actually helped her construct a more real picture of herself and others — she was able to move into a more independent and flexible way of relating. In fact, they provided a valuable resource she could trust in, rather than automatically avoid or question, even if acting upon them made her unpredictable. Lore only began this work, by the end of her therapy. However she was beginning to express and test her *IF* voice at level 3 in most events within her family domain (involving family members or fiancé), and to level 5 in the domain of her work relationships.

s 12 -255 APES = 4 *IF* clearly expresses self here, at time when L's body asks for change in self-demands.
[T] We've talked about spontaneity, and *letting go* before this....
[Cl] Um. I think I am getting better at letting go. I'm not getting so wrapped up in things....you know. I do feel.....I do feel differently, lately.
[T] So there is something about this time of the month.....a reminder, almost..... don't get too wrapped up in things. Just take it easy, and focus *in*....

[Cl] Uh-huh. Yes it is. I have to take it more easy, and not care so very much about how I look and then I feel better and can take better care of myself. But only at this time.....I do need to give in to my body.

As a consequence of owning some of her own negative feelings and evaluating the limitations of others as well as herself, Lore did encounter an associated fear: feeling isolated and alone. However, to her surprise she was enabled to take this risk, and some of her interpersonal interactions based on *IF* information benefited from it.

16. New understandings are applied to interpersonal situations

Part of taking these risks and owning her feelings resulted in a significant re-evaluation of her relationship with others, including her mother and her fiancé.

s 12 –720 APES = 5 *IF* able to express self more frequently and one scenario described.
[T] So even if something happens, you aren't reacting the same way.....
[Cl] Yes, uh-huh. I do feel different. I can't really .....put my finger on it, but I do feel it.
[T] Yes. Just more relaxed about what things happen....you will be okay..
[Cl] The same thing with my mother.....I am not having the same arguments with her as I used to have...a couple, maybe about two months ago...so I feel I diffuse it, before it gets too bad.

A month prior to the end of her therapy, Lore decided to end this relationship, and deal with the loss and grief it brought her. The depths of her response did not surprise her, even though she had not been satisfied with this relationship for some time. Lore was better able to call upon both inner and outer resources at this time. This was felt to be a significant development, as an over dominating *ACE* would have had difficulty allowing her to ask for nurturance from others during this time, or to give herself time to grieve.

s 13 -257 APES = 4 IF-voice recognises the reality of her changing mood while she goes through the early weeks of her relationship break-up.
[CL] I'm realising that some days are worse than others. Some days I am almost okay, able to do things and ....think. Other days, I go back into feeling....confused and hurt and all upset.....I can't...predict how I am going to feel. But I think that is...the way it goes. I can't be....okay with this all of the time. I am still feeling some .....shock about it all. [ ] I feel *awkward.*

17. New problematic voice emerges, opposed to accommodated *ACE*

At this point, Lore had not developed the ability to distinguish between instinctive feelings or impulses that informed her about her evaluative reactions to things, and another primitive and angry voice, which offered destructive criticism when she was frustrated. The *Bully* was a scathing voice announcing the incompetencies or

deficiencies in herself or others; as a voice it represented her aggression whether directed inward or outward. Its darker mood initially came up in occasional moments of self-criticism or anger towards others, in full form as attacks of frenzied emotion expressed outwardly or more covertly as half-finished words or muttered sentences. Initially this voice was attributed to internalised memories or fantasies about her cousin, who had indeed criticized her in the past and whose remarks pointed out Lore's basic deficiencies. Gradually she became aware of similar thoughts, which arose in herself, as an internalised voice of her cousin. The *Bully* was not part of the original voice pairing, but it has been described here as Lore's this emergent voice also began to intrude more as she became able to work with and resolve her *IF-ACE* conflict. The segments below identify movement in Lore's recognition of the identity of this new emergent voice, and her ability to own and sustain it longer.

***Bully* s7 – 050 APES = 2.6 Aware, accepting of depressed feeling and can talk descriptively about it (even though *stuck*; there is aliveness), and tone mirrors feeling. Related to outer events, but owned.**
[CL] So, yesterday I was feeling a bit low (*strongly spoken, blunt at end*) [ ]
[T] What kinds of thoughts were going on inside?
[CL] That I am failure, that..ah..what is wrong with me *this* time? (*slight sarcasm, anger*)...and I just feel that I am *stuck* where I am ....that I won't get out...from where I am.
[T] So these occasions make you feel even ...more...
[CL] Stuck, and depressed...uh-huh.

***Bully* s 8 -737 APES = 2 Through working on her *ACE- IF* conflict, L is able to see that eruptive emergences of angry feelings bring about depressed affect and confusion, and L is able to quickly relate this feeling to inner *'cousin'* (*Bully*) voice.**
L is talking about her mother's fits of anger toward her, and petty things L does to trigger it; she has also offered that her mother's menopausal state may be cause.
[T]].....And here comes Mom, saying, 'Not only didn't you do this right, but you didn't do this, or that.....'
(Cl) Yeah.
[T] You're not perfect!
(Cl) That's right. And that is a bit of my cousin [*inner voice remnicent of cousin*] coming back in....saying, 'You're not good at this' just like she does. It .....is a vicious circle, you know. (*sounds angry, but reflective on this*). Yeah.

A further movement began near the end of therapy, in which Lore moved into a deeper awareness of the inter-connection between her own critical, disappointed and frustrated, and consequently aggressive feelings within. She did come closer to the realisation that her need for *Bully* came from repeated exposure and attachment to others who did not return adequate affection and regard. Even though she could entertain the prospect of finding more satisfactory relationships, coming close to this awareness left her with fleeting experiences of isolation, without hope.

***Bully* s14 – 027 APES early 3 L is aware of *Bully* within; and its link with feedback from others, and how current situation constellates it as an inner fear about self.**
L is reflecting on her feelings about loss of relationship with fiancé.
(Cl) Yeah, sometimes I get to thinking, maybe this was the only chance I'll get....maybe I'll get worse, than what I had.....
[T] (*summarising previous self-criticisms)* Maybe you should have counted your blessings and not wanted a better relationship, you and Gary were as good as it will ever be for you. That sounds like someone saying to you, you should be happy with what you receive and not want anything more.
(Cl) Yes, it does. Total nonsense! (*laughs a bit, sadly*) Like my cousin saying, you won't get anything any better than this.
[T] It sounds like there is a fear there, like you might be punished for wanting something more, you ungrateful person. Yet something in you knew that this wasn't *right*, something wasn't going *right* and you weren't getting the attention and devotion you needed from a relationship...
[Cl] It was something I couldn't put my finger on for quite a while....he would....we didn't even have a physical relationship or anything, he ....it was very....he was like my brother....not that I've had a brother! But it felt like it was awfully very.....lacking something.
[T] Uh-huh.

18. Listening to *IF* and gaining ability to contain difficult feelings

Further, she could reflect on how *Bully* had been warded off. As *IF* developed in strength and presence, and *ACE* accommodated and softened in its expression, she began to understand how the masochistic responses and sadistic impulses arose within her at times.

s 14 – 220 APES = 4 Example of real insight, although somewhat led by therapist's interpretations, exploration and declaration of feeling sense is client's; *IF* is part of self and is connected to deeper feelings which used to be unacceptable to self- community. Now they are owned, and have value.
[CL] Yeah, and I don't like having these feelings.....I mean, I understand why I feel this way ....no....it's something else.....I think....it's about how it feels, to feel these things. It doesn't feel good, if you know what I mean...
[T] It's understandable to be envious and resentful, but it doesn't feel good to soak in these feelings for long...not pleasurable....
[CL] No.
[T] Is any of this, also about.....trying to be perfect again? Having these dark, difficult feelings takes you away from being light and fine?
[CL] Probably. I think so. I probably am trying to do what is expected of me. Again. But there is another side.....I feel I am getting too old to have a relationship.....there is a side of me saying....what am I going to do? (*real pathos in voice*).
[T] (*carefully*) There is something about the dark side of these emotions....you face, that....things might not turn out.....you might not be okay.
[CL] Yes! There are other .....I can see, there are other ways things might turn out....but it is less automatic.....It's.....about being nice. Thinking that way. I still like being nice. But.....you get taken a loan off, more. I.....don't like seeing.....myself.....this way. But it....feels real.....and I am not so....angry anymore. It is....still ....a bit hard.

Having opened herself up to this process, she did get in touch with other feelings of loss and emptiness, long buried. In the weeks that followed, her vulnerability released a host of feeling, including destructive ones, and she did experience depressive feelings that she chose to work through. This was important for Lore for three reasons. First, these feelings did not take the form of lashing out at others

or criticizing a deeper incompetence or failure in herself; although questions of self-competence did arise from time to time, she could respond to them herself, in a more supportive way. Second, she no longer found herself prone to accepting cruel *Bully*-like – or demanding *ACE* –like – remarks from others.

She suffered some new physical health problems as well. Her attitude about these and their cause revealed the growth she had experienced in relation to listening and responding to her own body.

s 17 - 091 APES = 4 Using insight from IF voice to own why her body is responding with symptoms; still needs to listen more but is on track. Old pain gone.
[CL] I've had some problems with my teeth....I've had a couple of abscesses.....I think this is because I am *run down* and it's affected my health.....I've been quite ill a few times....off my work.....things in my body seem to be going wrong....but I think this is all because of my state of mind, really.....feeling upset most of the time, and my body is feeling it too.
[T] You're body is feeling depressed, too.
[CL] Uh-huh.
[T] Have you had any pain, return...
[CL] No, none at all. It's not.....I am not worried about my health.....I think this is my body ailing because I am upset, you know.

Although in allowing depressed and grieving feelings she experienced a loss of motivation, temporary feelings of being adrift, and isolated, and these were difficult, she took appropriate steps to continue to set up a new therapeutic contract closer to home, once her project contract had terminated. At a three-month follow-up session, this was a creative period of work for her.

sFollow Up - 285 APES = 4 Linking events and pain, and pain seen as manifestation of repressed conflict.
[Cl] I hadn't realised how long it has been....that I haven't let myself feel.....something. I was trying to ignore it, and pretend it wasn't there.
[T] You were trying to ignore something....do you know what it was?
[Cl] I think it was the feeling, *this isn't right*.....I'm not quite....it isn't quite true, it isn't what a relationship should be....you know, especially a fiancé. You know, that kind of relationship.
[T] You ignored....wanting another kind of relationship, and felt this kind, where you did all the caring and taking care was what you should have.....you could trust this would be okay, and you could be loved in this kind of relationship.
[Cl] I just wanted to ignore how I felt about my fiancé.

She spontaneously contrasted her depression with her experiences of IBS-related pain from the previous three years, and said there was no doubt that for her, being depressed right now was part of *getting better*, and letting go of ways that had created her somatic pain.

6. 4. 4 *IndA – Child* formulation

Attitudinal perspectives representing *IndA* and *Child* are listed in Table 6.4.

IndA:	**I feel trapped, restless.** **I can be self-centered and concerned with my own development even if others are displeased.** **I want to be my own person, make my own decisions and be proud of my accomplishments.**
Child :	**I must be protected and cared for; so I need to give in and comply with other's wishes** **I need to be dependent on others in order to secure myself to them and get help when I need it.** **Being loyal and not getting above others is essential to deserving care from others.**

Table 6. 4 Attitudinal perspectives expressed by *IndA* and *Child* (Lore)

The *Independent Adult* (*IndA*) voice connected Lore to herself as an independent adult, able to choose for herself, freed from an overwhelming and sometimes unconscious concern about maintaining relationships. The latter concerns frequently appeared to put her into a passive or dependent role with others (*Child*). Her *IndA* voice desired the freedoms of adult living, but also recognised the responsibilities that came with them. Lore was aware of this voice as part of her inner world (i.e. at the start of therapy it received consistent APES ratings at late 1 or 2); that is, she had already accepted this voice as representing her intended voice at various times, but Lore's dominant *Child* voice feared she would not be able to cope with these responsibilities, and that she would lose the desired closeness and feeling of protection she acquired in her dependent role.

IndA was a distinct voice, and appeared somewhat split off from the rest of Lore's voices at times (i.e. Lore was not aware of its conflict with *Child*). She would express the importance of her independence and adult status at different times – in a different *voice* – from her acceptance of wanting to remain like a child, protected by stronger and more grown-up individuals. Early in therapy, her speech still bore a child-like or adolescent quality, when Lore eagerly and idealistically talked about her future plans (i.e. to her therapist she sounded like a little girl presenting herself as grown-up). She spoke proudly of recent acquisitions, which earmarked another gain into adult status or success in her pursuits (e.g. new car purchase, good progress report at work), but these sentiments were almost always presented

apart from a greater dependency, which marked Lore's lifestyle (i.e. the two concerns or values were not discussed at the same time). By contrast, *Child* enjoyed her restricted status, including her dependency on her parents at home. Lore insisted that she liked this arrangement, keeping a focus on its benefits in her initial descriptions. This arrangement kept her safe and free from some of the realities of having to take care of herself (e.g. doing her own laundry and paying bills), and allowed her to remain closer to her carefree days of childhood.

Lore also professed to *liking* the feeling of her emotional dependency, and the sense of a 'nest' of others being around her. Her metaphor for herself as a fledgling bird, wanting at time to take wing but otherwise feeling cosy in its nest became active during the work. Together, these presentations supported the dominance of her *Child* voice. Its authority was also indicated in certain frequent mannerisms: a physical posturing of a shy or excited little girl, facial expressions and vocal tones expressing innocence or vulnerability. Lore most strongly identified with being a daughter, and a young employee amidst older, more established personnel in her employment context. She spoke wistfully of losing childhood as an untroubled time when she spoke of her first menstruation.

S 3-100 APES =0→1 (*movement in session*) **Expression of *Child* voice and attachment to it; *IndA* is only allowed a brief initial expression.**
[T] How did you feel about having periods?
[CL] I felt...in a way quite grown up, having periods....and another part of me was quite sad about it, as well.....because that's my childhood, sort of passed....
[T] Um....you're right, it is a rite of passage. And what else was passing with childhood.....
[CL] Um.....I'm not going to be able to be a child.....I don't know, hard to say, really (*muses on*).
[T] Things will be missed, like.....
[CL] Doing the child things.....[*goes far away*]. Playing....(*voice sounds wistful*)...just all those sorts of kid things, that you would do. Then you are more...mature....doing things more on your own, you know...more sort of.....then the teen-age years, become difficult as well, so there is that to deal with...
[T] You don't get to play the same, and then have to deal with teen-age problems as well....
[CL] Yeah.

Her *Child* voice actively expressed the worries Lore acknowledged as her own, such as her need for others to help her cope with the tasks of living, and her fear she could not cope on her own. Important for the process of assimilating her emergent *Independent Adult* voice was the finding that initially she was not aware of the conflict this created with *Child.*

6. 4. 5 Assimilation summary across sessions

Out of an original set of 57 segments extracted by MR (the therapist –first rater), 32 were presented for assimilation analysis. This reduction occurred for pragmatic reasons (i.e. time constraints required a shorter set for analysis). However, segments included still covered the extent of the therapy, and were representative of other examples of voice dialogue (including one or both of the *IndA – Child* voices) repeated in segments of therapy not chosen for analysis. Fewer than 6. 3 per cent were considered unrateable for this voice set by the second rater (MG). After a second round of comparing ratings, and discussing verbal assimilation descriptions, consensus was achieved. This included 84.8 per cent where raters agreed on APES level; 9. 4 per cent where they disagreed (different APES levels were assigned by each). These ratings across segments achieving consensus in chronological order are represented in Figure 6. 2 (the segments determined as unrateable by the second rater (MG) have been extracted from this series).

IndA was partially assimilated as therapy began. Ratings moved from APES Level 1 or 2 to Level 3 consistently by session 5. *IndA* moved back to Levels 1 and 2 alternating with 3 for the next two sessions, and was consistently apparent at Level 3 in session 8. At session 11, *IndA* moved between levels 3,4 and 5, depending on the domain, or interpersonal encounter Lore was speaking about. In some scenarios, she was clear about her own values and beliefs, and therefore the stance she wanted to take in expressing her own views in these situations (Levels 4 and 5). In others, she struggled still between feeling overpowered by other's attributions about her, or how she defined herself (Level 3). The primary rater and therapist felt that assimilation of her *Independent Adult* voice may have been yoked in part to the development of Lore's access to her *Instinctive Feminine* voice, as recognising her own choices or values relied on becoming more aware of her feeling responses.

These comparisons proved pivotal for both Lore and her therapist in understanding the dynamics underlying these voices, and how interpersonal scenarios were capable of supporting or undermining *IndA's* appearance. Examples occurred

when Lore received blows from others' (or her own) appraisal of physical attractiveness. At these moments, she would outwardly become defiant and support her worth, but it was clear a struggle underlay these communications, and soon she would question her own self-perception. Similar slights to her work, however, had less impact, although an emotional response and some anxiety would still be apparent. On yet other occasions, choices of her own that had first been supported by thoughtful decision-making (e.g. leaving work early to fit in a personal appointment, choosing a dress that her mother later ridiculed) did not throw Lore back into Level 3 conflict, and she more readily tried out different ways of responding to these decisions and any reproaches that might follow, both overtly and to herself upon reflection.

What became clearer was that certain domains (e.g. physical attractiveness, intelligence) were acutely problematic for Lore, although giving herself support for situations in which she could exercise some control seemed to moderate any negative evaluation by others. As might be predicted, the loss of her primary relationship (session 13) was a major event that brought *IndA* and *Child* back into direct conflict again for a time. Most noteworthy was Lore's ability to use this situation to work diligently at understanding her own fluctuating responses from either voice (Level 4), and accept these variations with less anxiety than previously. *IndA* was able to address *Child* during this time, and Lore found she could offer herself self-nurturance, as well as hope.

This movement or pattern of assimilation for each emergent voice is depicted in Figure 6.2 below, which contains the converged rating set from both raters across therapy segments (these are listed in chronological order).

Once again, examination of the assimilation ratings across successive segments related to this voice set, and the verbal assimilation descriptions accompanying them provided other details and smaller processes occurring as *IndA* emerged more often and *Child* changed in its expressive qualities. At first Lore could only talk about *IndA* from her *Child* perspective, in which she viewed her ambition for independence as future and somewhat idealised goal. This centred on her moving away from home and setting up house separately.

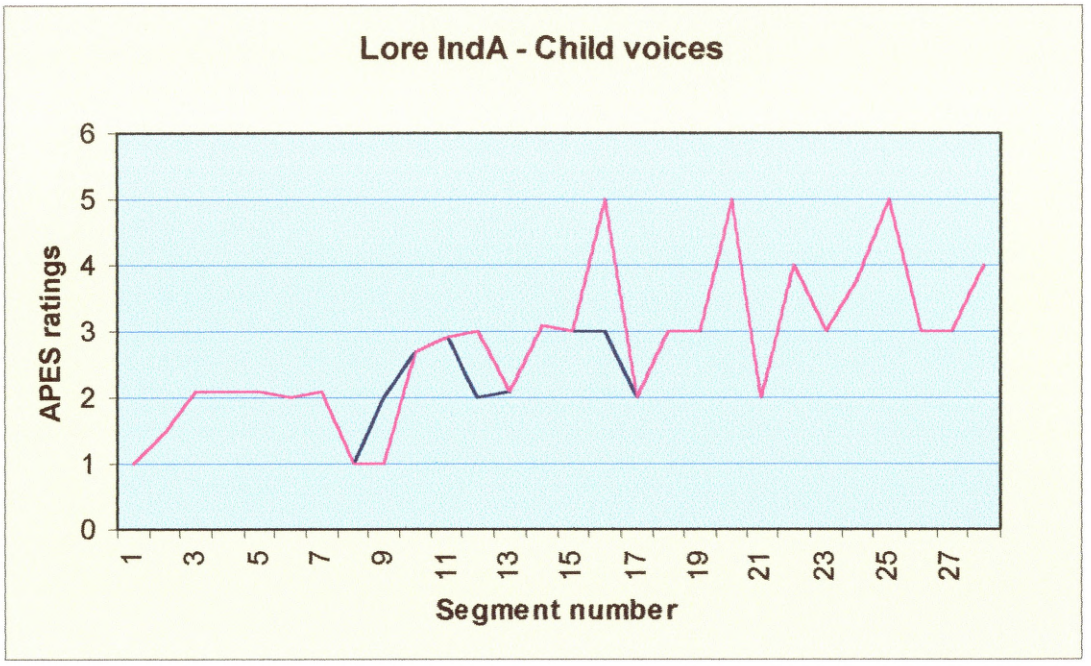

Figure 6. 2 Key movements in *IndA* assimilation and modifications of *Child*

Soon this conflict was perceived in her work domain, and to her ambivalence with her relationships and responsibilities at work. As with other voice sets described, these processes reflect more general stages of assimilation described earlier, but offer more detailed examples of what this movement looked like for this client in assimilating and accommodating these particular voices. They are summarized in Table 6.5, and then described below.

6. 4. 6 Key processes in *IndA* assimilation and *Child* modification

6. 4. 6. 1 *Child* is dominant and *Independent Adult (IndA)* emerges

1. *Child* dictates expressed values, and defends reason for being

Lore often described herself as still dependent on her parents in many ways, and not quite grown up. She felt her own development had been delayed during adolescence, which fitted with her therapist's impression of her, even when she spoke with pride about her job or accomplishments.

Processes observed	APES
Child is dominant and Independent Adult (IndA) emerges	
1. *Child* is dominant: dictates expressed values, and defends reason for being.	**0 -1**
2. Intrusions by *IndA* resented by *Child*, leading to further resentment by *IndA*.	**Late 1**
3. *Child's* dependency offers clues to its conflict with *IndA*.	**0 - 1**
IndA develops in strength	
4. *IndA* grows in strength in more than one domain.	**1 - 2**
5. Perceiving limitations of *Child*	**Late 1 - 2**
6. Development of self-boundaries as *IndA* assimilates.	**2**
7. Linking pain with self-other conflicts.	**2**
Conflict recognised	
8. Problem statement: awareness of conflict develops.	**2**
9. New levels of experiencing are discovered.	**3**
10. Further realisation of historical reasons for *Child* dominance	**2 - 3**
11. *IndA* is expressed more freely and its impact observed.	**Late 2 - 5**
12. *Child* and *IndA* return to struggle in conflict again	**3**
Impact of integrating *IndA* into self community	
13. Making a link between conflicts and somatic symptoms	**3**
14. Further excavation of voice history and development of meaning bridge	4

Table 6. 5 List of specific processes associated with assimilation of *Independent Adult (IndA)*

S 1 - 750 APES = 0.5 Unaware of conflict and vaguely aware of *IndA* voice; identifies with *Child*; that she offers a somewhat defensive rationale indicates a vague awareness that there is something wrong or opposing (i.e. underlying conflict).
[CL] I plan to stay with my parents for the next two years. By then I should have saved up enough money for my boyfriend and me to get a house of our own. So it is okay for right now. I don't think I would like living on my own, anyway. I need to be around people.....don't like being on my own. (*makes girlish grimace*) I like it that my mum does my laundry.....I don't have to worry about the electricity bill....

However in other exchanges, Lore would indicate her desire to become a 'complete' adult. To her, this meant having her own home and material acquisitions, a good job and the respect from others as a competent assistant in a prestigious company, and as a good person to have as a reliable friend but one who also knew her own mind. Independence and executive power to make decisions based on her own values were implied as goals Lore wanted to achieve in the future, indicating a dominance by *Child.* When the therapist in a later session asked her more directly about the apparent conflict this image created with the 'nest-loving' Lore, she could hold both pictures of herself only if she considered that the latter belonged to the present, and the former to her future. She was not

able to describe how a transition might come about, except that she would become more *ready* for independent living in time, when she had more time to grow up.

In addition to rationalising her living at home on an economic basis, Lore also created another reason for expressing *Child* which depotentiated her conflict with *IndA*. She insisted that her parents would sorely miss her presence, once she did leave her home of origin. This she frequently linked to the fact that she was an only child, and taking care of her was a mainstay of activity in her parents' life. She saw herself as responsible for filling a role in the family. Her own discomfort at moving from this role was also voiced by *Child*, however.

S 1 – 756 (*continuation from previous segment*) APES = late 1 Avoiding *IndA*... I'm not ready...Also externalises as explanation for her behaviour associated with *Child;* then returns to *Child* voice on dependency needs. Anxious; as if pressure exists from within to change.
I don't think I am ready yet for all of those things.....besides, it helps my parents, that I stay with them. I think I am..... a kind of entertainment for them. They don't have many friends.....and I am an only child.
[T] So when you finally do leave home, it may be difficult for both of you.....for you, being on your own .....for your parents, losing their child.....leaving the home empty...
[CL] Yeah, I think it will be harder on them, really. I am really just about all they have, and they like me to come home and tell them about my life. But I like the situation just as much.....I live in a nice home, in the country, and have everything done for me, I just have to go to work, really. So it is nice! I kind of panic, when I am alone and don' t have others around. I need to be with other people.

The therapist noted the strength of Child and offered acceptance for its views and needs. Her role in safeguarding Lore's position near others permitted the security she craved. In describing these needs and values as a *part* of her, however her therapist attempted to gather and name these qualities together as a recognizable object or *voice* within Lore.

2. Intrusions by *IndA* resented by *Child*, leading to further resentment by *IndA*

From her dominant *Child* perspective, intrusions by *IndA* were perceived as selfish. Lore reported that this point of view was supported by her mother, and occasionally by other relatives. In the following segment, Lore expresses her doubts, then her angry resistance against seeing herself this way, revealing that *IndA* on occasion created a more active conflict with *Child* when she attempted to return back to identification with her dominant voice.

S 1 - 362 APES = early 2. Emergence of *IndA*. Starts with introjecting others' description as selfish (late 0), however, and remains vague and confused although using logic to defend *IndA*. *Child* creeps in with doubt, however.
[CL] My mother thinks I am selfish. When she is angry and starts yelling at me, then she tells me how selfish I am.

[T] How do you feel, when she yells and calls you that?
[CL] I am hurt.....I worry, maybe I am being too self-centred? But most of the time, I don't think I am....she is just angry because I won't give her something she wants, like borrowing my car.
[T] Do you think she knows how you feel, when she does that?
[CL] No, I don't.....I don't think she is thinking about how it affects me at all. My stomach will begin hurting, and sometimes I have gotten quite ill after my mother has been shouting at me.....and then refuses to talk to me, for quite a long time, afterwards.
[T] So your mum tends to be selfish, in a way here.....she wants something, and it she doesn't get it, she tells you, you are the selfish one.....and then won't give her attention or try to patch things up.
[CL] No, usually I have to patch things up, by trying to talk to her, or apologising.

Conflict was mentioned vaguely as a problem within the family home, but this was warded off in humorous portrayals as deriving from Lore's chronic *irritability* due to work stress, or that something in her was *out of balance*. She appeared to see herself in the role of the problem-creator in the family, through her occasional illnesses and emotional upsets in the family. She tended to remain apologetic for creating trouble for others. These external, interpersonal events rendered her ability to sort and understand her inner perspectives difficult, as it was unclear whether others might be offering conditional approval for *Child*.

3. *Child's* dependency offers clues to its conflict with *IndA*

Early on, *Child's* expressions included a desire to be close to – almost enveloped by – others, which Lore herself had associated with her *nest* at home, and as an image within herself. Her therapist felt that this indicated some anxiety in her need to feel surrounded by close relationships, and an expressed concern over maintaining relationship with others. For example, expressing loyalty and gratitude for other's care and attention or gifts had been very important to Lore, with frequent dialogues about appearing grateful. These dynamics were likely to have some role in *Child's* ability to ward off *IndA* at times, and were considered relevant to the nature of their conflict with one another.

S 3 - 350 APES = 1 Recognising strength of and liking for *Child*, and its impacts on sense of relatedness and security. Some vague indication that at times she disapproves of cost (*IndA*), but *Child* runs right over this voice.
[CL] I don't like to let people down.....I like getting the approval from others. My boss, he doesn't actually say, but I can tell he is pleased. Sometimes I am asked to do too much. Like, over my lunch, I am asked to do something. But I think, that is my nature, I really like to do things when I am asked.
[T] You are pleased to be asked...
[CL] Uh-huh. It makes me feel good, that they know they can count on me.

At times, however, she became dissatisfied with remaining identified with *Child*, and Lore realised that she was also discontent with her job and her situation at home. These were usually times when her own needs for self-enhancement had not

been met. Earlier, these moments were expressed as diffuse restlessness. Before long, however, she was able to consider these experiences in therapy; her restless feeling became a voice that could express what it wanted.

S 4- 090 APES = 2.7 Both Child (bold) and *IndA (italics)* speak, back and forth, and the conflict is directly experienced, although *Child* is still dominant and problem not fully owned. Child's concerns are transferred to therapist.
L is describing a job interview coming up; she is excited but trying to manage her anxiety and potential disappointment if not successful.
[Cl] **I know it sounds terrible.....***but I would really like to leave the job I am in. I've been there six years (carefully)*
[T] What part sounds terrible?
[Cl] *(pause)***Well, not that I am ungrateful**, but.....*I have to look after myself, so I can progress. You know, do something for me....*
[T] But, you are .....a little worried.....that I might think you are ungrateful....
[Cl] Uh-huh.
[T] And if you were really grateful, I mean *sincerely*, you wouldn't be looking for another job...
[Cl] Uh-hm. *(in a rush) I must admit, sometimes, people at work.....I find, I could do with a change in environment.....[ ] I work with someone who suffers from depression, and sometimes I find it....I would like to work....in a happier environment, because.....*
[T] Sometimes with the depressed lady you find it.....
[Cl] **I know it sounds terrible, because she's got an illness....**
[T] Okay, so you are worried about being ungrateful...because you are looking at a new job, and you are worried about being terrible...you don't want to be around a depressed person.
[Cl] Uh-huh (*quietly*).
[T] Let's try to stay with this a moment, can we?
[Cl] *Uh-huh.(more assertively)*
[T] I might think badly about you, and not know how much you really do care about people...
[Cl] (*laughs*) That's right!

Lore was also aware that occupational success in the world of others represented a missed achievement for older women in her family (e.g. her mother and grandmother), who had both talked wistfully of their own career dreams lost during marriage and motherhood. Reflecting further, she could see that the occasional negative evaluation she received from them (especially in comparison to her high-achieving cousin) might represent a mixture of criticism and envy, although these comments still hurt her. She was not able to understand why she (with her only partially established adult status) might be a more likely target than her more successful cousin, however.

However she did begin to see how this interpersonal conflict might be represented as an internal opposition, drawing her to choose between staying close to her current lifestyle and establishing even more independence. She continued to focus on these as external messages, and interpret them as a warning that she should not expect similar success; that her own abilities were more limited and it would be embarrassing if she tried to get above herself. This became an outer pressure, which was perceived to combine with her inner concerns to suppress the

emergence of *IndA*, which had a paradoxical effect (i.e. *IndA* struggled to emerge harder). This brought discomfort for her dominant *Child* perspective, however, and so a cycle of restlessness, partial *IndA* emergence, re-assertion of dominant *Child*, and depressed feeling continued.

S 2-678 APES = early 2 Using own *IndA* perspective to understand grandmother, and able to maintain in awareness, but vague, and sense of nervousness and discomfort in doing this. At end, can acknowledge feeling associated with *IndA*.
[T] And you ended up spending time with your Gran who spent much of her life mothering.
[Cl] Mmm hmm.
[T] If you gave it some thought for a minute..... what do you think were your grandmother's regrets, for her own life?
[Cl] Mm. I think possibly not doing, not having an actual profession. You know I think she got married quite young and ended up having quite a lot of family, you know and there was things she probably wanted to do but....didn't have the chance, like you know.
[T] It's harder. So you think she had some professional aspirations .....but got married.....and so then when your cousin comes along and your cousin is very successful in that way.
[Cl] I think actually, it's often like that. (*slowly*) The children become.....it's like an extension of themselves, you know and because it's the family, you know, it's quite, this is the first person to really succeed. You know, it's quite....(*trails off*)
[T] (*slowly*) So this is, she's doing what..... I didn't get a chance to .....but really wanted to..... so she's just connecting with that..... and then you come along.....
[Cl] (laughs).
[T] And there are the two of you.....only with you, because your mum is working, your grandmother becomes a temporary mother to you as well.....and she talks to you about your successful cousin, whom she admires.....
[Cl] Really, I was quite depressed about it.

6. 4. 6. 2 *IndA* develops in strength

4. *IndA* grows in strength in more than one domain

IndA was growing increasingly vocal in relation to her workplace, and Lore's recognition that she had grown out of her current job. She needed the challenge of more responsibility. These responses to her own dissatisfaction were entertained longer, without immediate and contrite responses by *Child.* Regarding work, Lore talked about wanting to be recognised and achieve; yet she still relied on idealised fantasies of a future life, rather than exploring more reality-orientated possibilities.

S 3- 284 APES = early 2 L is more relaxed about recognising strivings to move out and up, and establish herself (*IndA*), but expresses feeling that these are distant goals - maybe not even possible (qualifications by *Child* re-asserting dominance).
L talks about a young woman featured in Hello! magazine.
[CL] I would like some of her.....money, and accomplishments, and friends.....but my own job won't get me there.....
[T] What would you like to do?
[CL] I would like to do the same sort of thing, because I really like my job. But where I am is really dead end. I would like to continue to be a personal assistant....well, really I am a secretary and sometimes fill in for the woman in my office who is the personal assistant and manager for the top boss. That is what I would like to do. Hopefully, one day.
[T] But this also might mean, leaving (*names city*).
[CL] Yes. Probably it is likely, as there aren't too many jobs like that here.

[T] I get the feeling of wistfullness here – you would really like to have the things and lifestyle of this lady, yet you realise that you would have to lose some things too – being more independent has its price.
[CL] Yes, and I don't think I am ready yet.

However by the fourth or fifth session, Lore began increasingly making appraisals of her own work products and those of others, as a different way to acknowledge her ability and readiness for a new and more authoritative role.

Occasionally Lore was aware that she was constrained by the relatively enmeshed relationship she had with her parents, by having to comply with certain rules in the house, or because she desired to spend more time with her fiancé (who also lived at home with his parents), but she was confused about her own sentiments. If appeared that she could not envisage a solution to this conflict. At these times, the therapist spoke to Lore's *IndA* voice, when it emerged, to try to give it a place in the dialogue. One example involved the negotiation of the session boundaries.

S 3 - 005 APES = early 2 Therapist-led discussion with *IndA: i*nitially *Child* voice makes compliant choice; therapist attempts to negotiate by requesting *IndA's* comments.
A mix-up in understanding about session start time; therapist offers re-negotiation while clarifying.
[CL] No, it's fine by me, really, I'll be glad to come at 6:30.
[T] But....what I ....I wonder if we could go back and start over with this decision. We have two possibilities for starting times, and both are possible for me now. So I'd like to hear, what would be best for you.
[CL] Okay. Just trying to think.....by the time I get home, it's ....I would say, tonight....(*murmurs to self, thinking*) ...I'd....get here by.....say, 25 to.....but I could make it earlier, say at half past six (*still mulling this over*).
[T] I get the feeling that is really making things tight for you.
[CL] Well.....yes, a bit.
[T] So it would seem a bit later would make it better, less pressured..... and I'm saying this is fine with me as a starting time.
[CL] Yes....okay, so can we say....quarter to?
[T] Yes, quarter to seven would be fine.
[CL] *Sits back and gives a little smile.*

Other early emergences of *IndA* involved isolated expressions of counter-dependency. Lore was conscious of her desire to be in charge of others, at work and in planning a future with her fiancé. Again, there appeared to be a split awareness or parallel reality to her narrative here, her insistence that she liked this image of future control over others could not be related to her fear of taking responsibility for herself in yet current situations. This fit the hypothesis that *IndA* was struggling to gain presence, and gave Lore a connection to an inner world that got lost, or disconnected when she was dominated by *Child.* She was initially unaware that her insistence in taking control over managing their affairs helped her

avoid the more usual state of feeling merged with others and dependent on their help and care, and therefore remained a warded off solution to this conflict.

S 4- 299 APES = 2 *IndA* speaks and tries to appear strong, but in an unrelated way - and refuses any indebtedness or dependency to others. Either –-or nature of voice relationships indicates this is temporary emergence and unconnected to either dominant voice, or conflict with it.
[T] What if you needed to take a loan, temporarily?
[Cl] I wouldn't like that, I would feel like a failure. I don't want to ever have to take money off anyone. I just don't like being...indebted to someone.
[T] It is like there are two things, here. On the one hand, you want to live at home, and don't feel secure when you think about being out on your own. You really are more comfortable having people around you. But on the other, you tend to *push away* from others close by, when the issue is money, and being indebted to others. It feels too dependent.....it takes you..... away from yourself
[Cl] Yes it does. I detest it. The thought of it makes me.....quite ill. [ ]
[T] If you owed something to somebody, it would mean....
[Cl] I've failed in some way. Something is.....not right.
[T] You have to push yourself against failing.....*so hard*.....that it...you can't ....even give yourself an inch.
[Cl] That's right.
[T] It is more than .....just valuing your financial independence. Something you like, sure. It is the inflexibility....you can't let yourself lean on someone ever, not even for a minute, if you were ill, or needed a rest...or whatever..
[Cl] Yes. Not for a minute.

At these moments Lore's resistance to any form of dependency appeared to help her focus on striving to manage by herself, without help. An implicit conflict was felt, but only in a vague way.

Her portrayal of her fiancé, although consistently positive, occasionally included his hapless planning or management of events or money management, and Lore took over this role here eagerly. Her fiancé was reported to be amenable to Lore's taking command of finances and managing plans for their future. This implied his dependency on her, but Lore appeared to be unaware of this consequence, or that it might be related to her own struggle to resist a similar dependency within her own conflict.

S 4-270 APES = mid- 2 *IndA* emerges, describing idealised conditions necessary to feel comfortable: lots of security and attractiveness. Also L recognises she has ambitions for self-fulfilment, but these are still vague. Plans with fiancé don't have mutual interdependency.
L is talking about her plans for marriage and job plans over the next two years.
[Cl] That's me, I am comfortable enough now, but I want to get more money. And two years, that will mean I've been with the council for eight years, and I *should* be able to get something by then. This job [*the job she has currently been shortlisted for*] will help. I want to build enough security up for myself, before I leave home.
That's just me. I have to over-do things, to feel secure enough to make changes.
[T] So if you get yourself all sure.....completely sure, then you will be able to take a risk.
[Cl] That's right
[T] That's interesting. Some people might think getting married might be one way to be secure...

[Cl] (*thoughtful for a moment*) There's that side, but I think....financially, it has got to be right as well. I've got sort of, ambitions, and I want to fulfil that, as well. I still sort of....I don't need to leave home at the moment.
[T] I guess, one of the things I was thinking about a moment ago, is that with your fiancé, the two of you together would be earning more money.....
[Cl] Well, I earn more than he does, in the profession I am in. He's just a travel agent. He does get .....a basic.....pay. But most of his earnings come from commissions....I think I would have to be the basic....breadwinner. It would have to be based on, what I am, more.
[T] You'd like to think about....being able to depend on....yourself, rather than someone else, more.
[Cl] Uh-huh. But I think I've always been like that. I've never asked my parents for any loans, or money, I do it by myself. I'm sort of independent in that way. I kind of like that. I've got my own car, and that.

Occasionally, her projection into the future where she would manage their joint finances brought moments of anxiety and feelings of isolation. At this point Lore was still unable to consider what a more mature form of inter-dependency might look like, when she talked about a future with her fiancé.

5. Perceiving limitations of *Child*

Eventually, Lore made a link between her compliant and dependent responses and dissatisfaction, which resulted in a perpetual cycle. It provided a link to her abdominal pain as well.

S 3 –391 APES = early 2 Can perceive compliant *Child* as a lack of assertiveness *and* that sometimes, this may cause pain. Can own this voice and perceive its limitations.
L is talking about her reluctance to say what she thinks even when it means others give her more than her share of the responsibility.
[CL] Yeah. Just...people might think that, because of what I'd said. And I'd blame myself for saying it. I'd rather not say a word. It is just my nature.
[T] So where does the annoyance go, when you end up feeling taken advantage of, given even more work to dò? That you don't get good feedback.
[CL] I think it goes straight to my stomach. It .....starts.....to .....affect my stomach.

Her *IndA* voice continued to emerge as she worked on her plans to improve her career as a personal assistant within the council, and discussed her thinking and evaluated her own likes and dislikes in work related duties with her therapist.

In other domains, even *IndA* expressions were coloured by *Child's* idealism in some way. One area involved her need to acquire material things. These were occasional, but strong impulses for Lore, for new jewellery, cars, or clothes. When prompted, she associated these acquisitions with achievement. Another was the emergence of feelings of competitiveness, which at times bothered Lore, but at other times she recognised her enjoyment of them. In developmental terms, these might seem natural adolescent experiences in which Lore might measure her own abilities and choices by comparing herself to others. Earlier Lore had described

her dislike of these feelings, and evaluated as immoral, but she couldn't say why. In a preceding session, she related to the inner feelings of these moments, and made earlier tentative link with states of anxiety and pain. This confusion provided useful ground for her to begin to sort out how she wanted to think of herself in comparison to others, however. In the passage below, she has temporarily moved back toward her desire to remain a *Child* and keep her relationships unperturbed with her own needs for self-advancement, but even this regression is experienced with more discomfort.

S 4-468 APES = Late 1→ 2 Begins with Level 1 experience (confusing and entrenched response), with high anxiety and emotion. *Child's* despair is wanting to be comfortable, and rid of competing with others, but *IndA* emerges again + knows she also doesn't want to give it up (this feels too anxious). Recognises that this is a problem (doesn't like feeling, and links with pain), but has temporarily sunk back into entrenched *Child* position, with more discomfort in doing so.
[Cl] I don't think I will ever get rid of this……competing feeling.
[T] Competing with yourself….
[Cl] Uh-hm. I don't know how…….to sort of…….change it….
[T] But a moment ago, you also said, you didn't want to…..you were comfortable being this way…….
[Cl] Some people say to me that I'm always a kind of edgy……..person. And I know it is because I….not that I am always trying to impress…..but that I always want to be good at what I do……I wouldn't want to be someone, where I let something slip…..a lot of people say to me, you're always…..not, you're always on edge, but…..you're always……..you can't let go…….you know. I think, there is something wrong, if I did that…….
[T] You don't like letting go at all…..
[Cl] Yes.
[T] ….because if you did, you might end up feeling like a failure, angry, or something……
[Cl] And so, I think, maybe, something……maybe, that is why my stomach is the way it is……..because I am always on edge, and can't really help it……
[T] I think you are right, that there is some kind of connection there….but it isn't easy to know how……or what……to change, and still be who you are…..
[Cl] Uh-hm. Yes. I don't know how to combat that…..
[T] What I think I am hearing now, is that you would like to change part of this *way* of yours…….the part that is connected to the stomach pain……..but not have to change all of it……the part that keeps you proving your worth to yourself and cares about doing a really good job.
[Cl] Yes! I think I've been living by my nerves…….

6. Development of self-boundaries as *IndA* assimilates

Her therapist became aware that in part, Lore's attention to impression management was part of a more general other-focus, that included her need to compete and win, and receive admiration, and continued feedback about her accomplishments. Such feedback would help her shape her own views of herself as a unique person. This was different than simply wanting to avoid the risks and uncertainties of adulthood, and being held back by fears from past traumas. It occurred to her therapist that Lore's *Child* dominance might have become necessitated in the absence of adequate developmental opportunities for *IndA*. Her

emergent voice might still be primitive in form, rather than just defended against. Lore's continued experience of her *IndA* as an inadequate, or immature *self* might reflect a real developmental deficit. On several occasions Lore described her problems as related to an inadequate boundary between herself and others. This provided another indication that she experienced difficulty in acknowledging herself as a separate person.

Early on in her therapy, Lore had described herself as a *magnet* for others' unhappy feelings or problems. She felt she attracted something at a feeling level, and that others seemed to find her convenient for taking on blame or responsibility for their state of affairs, usually discontented ones. She did not like this quality but experienced it as part of herself, and was not able to connect it to the enmeshed relationships she tended to create with people earlier.

S 7 - 650 APES = late 2 Discussion of merged experience as part of growing awareness that she takes in other's feelings, and has insufficient boundaries. However L agrees + furthers exploration by working with inner experience (i.e. *this happens elsewhere* and *feels central to me*).
Experience of depressed co-worker has been explored, in last few minutes therapist has offered that this outer relationship taps an inner one for L.
[T] So she's putting these feelings into you.....it feels like she is putting these feelings into you, you feel they have been taken in.....this unhappiness, this anger, this criticism of your worth...no wonder you don't like this part of your work.
[CL] Uh-huh.
[T] It's like you have been carrying these feelings, for her. Carrying this weight, this heaviness [ ] for her. She's off-loaded it, and you remain stuck with it.....We talked a bit before about your, maybe, being someone who tends to carry feelings for other people.....somehow, when others get upset, or.....not just once, but more generally.....they may need someone who can carry some of their....bad feeling....
[CL] Uh-hm. ..... It has an effect (*softly*)
[T] And you get left with feeling....
[CL] It's actually quite funny, but when I.....when things are not good at home, I tend.....as you say, I feel loaded with it....I tend to carry everyone else's problems...like my mum's not good....and my dad tends.....but you see, it tends to come to *me,* I seem to intercept it. I seem to be like a *magnet*...for...everything that goes on.....that kind of.....thing. [ ] And sometimes, I actually feel sick, I feel physically sick. It's terrible....it's like being sick.....to your stomach. Something that eats away.....because you begin to feel, *it's me.* It's *me* that has caused the depression...the problem.....something about me.....and it makes you feel rotten. You do.
[T] Your magnet brings in their energy.....And being a magnet reminds me, what we have been talking about here....that you are learning how to separate out, what is yours and what belongs to someone else. Your own feelings and thoughts about you, from other's thoughts and feelings, whether it is about you or something else.

Setting boundaries regarding what she would give to others was another desire expressed by *IndA*. Less often did *Child* intervene and reduce Lore's need to maintain separateness, as Lore began to see the shortcomings in *Child's* thinking.

7. Linking pain with self-other conflicts

This recognition also appeared to help Lore link her pain with her problem of establishing firm boundaries with others, rather than being concerned with staying close to them. Often examples included confrontations or occasions in which others were upset, and left Lore feeling as if she was holding their distress (or responsibility for it) in some way she did not understand. She still could not articulate these phenomena in terms of her inner conflict, however.

S 7-700 APES= 2 Lore recognises link between somatic symptom and interpersonal conflict or being with others who are upset (introjection). She sees problem in part, but doesn't understand it.
[CL] Because it really flares up. The pain. My stomach. When I do have……a confrontation, it's a bother. These confrontations, they affect me quite badly.
[T] Hm. (*sympathetically*) I know they do.

However, avoiding conflict in her outer relationships was not always possible, especially when others were angry. Two examples predominated. One involved her mother, who appeared to frequently get upset with Lore when she unintentionally broke the rules at home, or denied her mother privilege to her personal belongings. These left her drained, for some time afterwards. Another involved a co-worker, who was often reported to find fault with Lore. During the second half of her therapy, Lore grew more able to access and maintain her own perspective about these conflicts. She perceived other reasons for her co-worker's anger and criticism (for example, the woman's general state of unhappiness), for which she realised other causes existed.

6. 4. 6. 3 Conflict recognised

8. Problem statement: awareness of conflict develops

Near the mid-point of her therapy, Lore was more in touch with her frustration over her lack of advancement at work despite her attempts to secure a better post, and these expressions of *IndA* became less censored. Unlike previous occasions, however, *Child* values and concerns could also be entertained in the same discussion.

S 7 040 APES = 3 As L attempts to soften her feelings of complaint and stuckness regarding the conflict between *Child- IndA*, but states problem.
[Cl] Don't get me wrong; I like what I do. It's just…….it's just….I'm stuck in a rut right now……I feel I've been in there ……..too long……..I want to try…….and experience…..new things (*gives movement of impatience with hands*) just now…

[T] (*summarising from earlier Lore's dialogue*) Here you are in your life, trying hard, trying really hard to make changes....and you know [ ].. it isn't that you aren't good enough, you are not trying to hold yourself back .....but just that it's not happened yet.
[Cl] Yeah. It's more like frustration, you know.
[T] It's your turn.
[Cl] Yeah, uh-huh.

Embodying this conflict helped Lore realise that she did have some doubts about her abilities. Now she felt more able to face these doubts.

S 7 – 085 APES = 3 L realises her previous stuckness is related to inner self-doubts about competence (*Child*), but now she wants to try but is not getting opportunity.
[CL] I think I can do more. It's.....just the fact.....that....*I can't get in, again...*
[T] Part of you knows that you are good ....just waiting for a chance .....but there is still some hesitation here, maybe, like, show me the evidence.....
[CL] Yes, uh-huh!
[T] But you can't show, until you have a chance to....
[CL] I think part of me still is unsure. Like at school, I worked very hard to get the marks, and pas my courses. Some people, they didn't seem to have to try at all. But I.....don't know. I just want to get a better job, more responsibility and be able to try. It doesn't feel fair....

9. New levels of experiencing are discovered.

Lore was still assessing her competency-in –action. Her skills and self-confidence grew and could be applied in different interpersonal encounters, more flexibly. In the session dialogue, Lore's reflection had shifted to a different basis, one that reflected a more reasonable expectation of herself, rather than an inflexible ideal. Her narratives appeared to be more grounded in interpersonal encounters and her reflections on them; as she described scenarios to her therapist, she was also musing on their meaning to herself (i.e. with the expression, came an experiencing).

S 7 - 110 APES = 3 Experience and expression of *IndA* competence, and being able to specify how she is able to apply *IndA* in learning and using skills. No anxiety here, and vocal tone different.
L has been reflecting back to a recent series of events, in which her skills surprise her a bit, but she also feels comfortable with them. Both experiences come through the feeling tones in her voice, which the therapist hears as deeper, richer.
[T] So getting along and being able to communicate with those who are higher up - more powerful - in your organisation is something you have found you can do.
[Cl] Yeah, uh-huh, I've learned a lot, by watching others....what they do, and what not to do....I think I am assertive. Like, ...especially when I need to prompt, to tell one of them, you've got to do something, keep them on track....here I am, telling the director! At first it was difficult, and then I learned, maybe the way I approach it, it makes a difference. It takes skills. You have to .....remember everyone who might be concerned.....you can't go in, barging in and just beat your fists....
[T] And you've taught yourself, these skills..
[Cl] Uh-hm. Yes.

10. Further realisation of historical reasons for *Child* dominance

During this phase she began to express more understanding about her conflict between her desire for independence and her need to stay 'nested' within her relationships with others. While it lacked the quality of true insight, Lore began to realise that the strength of her need for others was connected to a fear of losing them, or feeling panicky about finding herself at a distance from them. She demonstrated a tentative appreciation of how this fear had provided an obstacle to her making forward changes in how she responded to people and events, and that this obstacle lay inside herself. In particular, *Child* feared separations, and tried to avoid risking rejection; or anything which provoked a central experience of *loss*.

S 8 - 900 APES = 3 Lore is able to give voice to both sides, and alternate.
Therapist has been talking about how normally, children grow up and leave home by their early twenties.....involving an adjustment for both children and parents
[T] ...any thoughts about why not? How do you understand this, from your perspective...
[Cl] You see, there is a part of me, that wants to go *now.* Can't wait.....but then, I have a nice home, in the country, and I know loads of people there....
[T] You've got a nice situation there, and feel comfortable ....and you're *known.*
[Cl] Uh-hm.
[T] Different parts of you come up around home, and your parents.....and when you think about going, you get split into at least two .....[ ] ...What will be the worst part?
[Cl] I think, not being part of a home.
[T] (*pathos hits, she looks like a very lonely waif*) It feels like losing a warm home that you were at the centre of.
[Cl] That's right, it has felt very ....secure.....

Now she could make a link between her earlier awareness that achievement for women in her family offered its costs, and her own expressions of compliance in order to gain affection. Gradually Lore began to realise that this fear permeated her responses to events, and had become an underlying anxiety. Earlier she had become aware how much her sense of esteem was dependent on approval for her industry, from others.

S 5 - 528 APES = 2 Both desire to achieve for self (*IndA*) and need to get approval and affection, and therefore stay close to others are both present; sense of struggle present.
[Cl] Yes, my bosses like the work I do.....but I've never been.....a person to be.....complimented much. So I think, if they say....oh, she does a good job...that also comes out. I've never....been much.....so I'm trying to .....if I can be a perfectionist in my job and relationships at work..... it is something I like to do anyway.
[T] (*mimicking her thought*) It is a way that I can get affection.....admiration from.....others.
[Cl] Yes. It is the *only* way I can.

As her trust in the therapeutic process grew, she explored these feelings. For example, as she was able to express *IndA* without a subsequent and compulsive feeling of anxiety or apology, she discovered a potential *inner* loss of good feeling.

S 10 – 850 APES = late 2 Exploring consequences of *IndA* as way of learning how conflict remained stuck; earlier outer experience becomes located as inner one and can reflect from *Child*.
Therapist is trying to encourage L to let go of her compulsive perfectionism(part of her approval seeking) in her imagination, as a way of exploring conflict.
[T] I guess I'm suggesting you let yourself *become... feel into* what it would be like to be someone who has been sloppy, not caring about leaving things out of the fridge, leaving work early to go to your doctor's appointment.....they're right, you don't care. What does that feel like, to be someone like that, on the inside?
[CL] Oh.....(*grimaces*) I feel, cold, I-don't-care. I don't care about how anyone feels, I am just suiting myself. They....their feelings don't matter to me. No [ ]
Later in dialogue, in role-playing a new feeling response to an actual incident at work when receiving unfair criticism:
[CL] . It feels.....cold. Callous. I don't care about her feelings at all. I would say something .....biting, nasty to her....I might tell her what I think of her.
[T] Can you voice this, here?
[CL] That.....that she is just a sad woman.....I see that she complains about things because she is really sad and lonely and that is no reason to take it out on other people. I think she is worried about her job.....I feel I can do her job, better or as good as she can.....some things I do better than her, and I might tell her so. It doesn't matter if I take this time off, I get more work done than she does, anyway.

Even near the end of her therapy, she was actively exploring these dynamics in relation to a major loss to her relationship network.

s14 - 245 APES = early 3 Exploration work and reflection, on fear of losing attachments and therefore need to stay within other's expectations. Hope for different future, less dominated by earlier fears is expressed, amidst deep pain of loss .
[CL] There is part of me that fears, being left. I think I've had this worse, than other people.
[T] Yeah, there is part of you that really fears this.....not just like, everyone doesn't like endings really. This is deeper.....takes your breath away a bit.
[CL] Yeah. It's just really.....(*searches*) I think it is because I am an only child. If my parents went, if anything happened to *them*, it's only *me*! You know. There is no one else.
[T] Wonder....if that could be part.....of that fear, of not being able to risk displeasing people.....
[CL] Yeah. But I think this is eventually going away.....other people do come up, after all.

11. *IndA* is expressed more freely and its impact observed.

Lore began to offer a more reflective consideration of her choices, and the reasons for them, including the location and future prospects of new posts. For example, earlier in session five, she applied for and was short-listed for three choice jobs, and presented concrete plans and modified her goals in a realistic and appropriate manner. She was able to cope with her disappointment well when she did not get the posts, but could evaluate her performance (and receive feedback) without denial of her disappointment, or with other *Child*- like feelings of guilt, shame, or self-criticism. This was a relatively isolated event, however.

s 5-018 APES = 3 L learns from incident she can evaluate well and there are in-between states to all -failure and all- success
L has just found out she did not get the job; she is disappointed and her voice low and sober, but acknowledges that she got positive feedback
[Cl] Well, I did get a very good interview, because I actually got feedback! That I came across very well....and I was second choice, but unfortunately only one job can ....be offered.....
[T] So that left you feeling.....not as bad.....
[Cl] That actually helped me quite a lot, because I was actually beginning to think maybe it was the way I was presenting myself....
[T] What were you worried about?
[Cl] Lots of things. I didn't say the right things, didn't come over...as.....very.....confident.....I since feel that maybe I do come over....well.
[T] Okay. Not being confident enough, worrying about shortcomings.....this has been part of you...
[Cl] Yes. (*immediately*)
[T] In the past, you....might have even....ignored that feedback....
[Cl] Yes! You don't know really how other people perceive you....you feel you are really bad....
[T] So.....it is a consolation.
[Cl] Yes...[ ] I did learn from the feedback, that I am employable.

These once-isolated instances in which *IndA* was present in thinking and perceiving increased in frequency over time. Lore was gradually able to use her ability to think in order to gather some perspectives on her confusing feelings. She began to perceive that some of the impact of outer criticism or disapproval was that it constellated her own feelings of incompetence or deficiency (*Bully* voice), and her fear of being alone.

As *IndA* emerged more often, and the therapist attempted to meet her empathically, Lore could accept the invitation to become more focused *–in*, in her experiencing.

S 10 - 800 APES = 3.4 Entitlement Both voices present and L is able to choose independently how she wants to act in incident, apart from fear that others will think less of her.
[T] So you left work early, to go to the doctor's? That is unusual for you....
[CL] Yes. I needed to go, it was my follow up. So I took off a half hour of work. It didn't bother me to do that either. I wasn't so worried about it, because there was a good reason, and we weren't so rushed at work anyway....things are lighter right now.....
[T] So the part of you that says, what about your workmates, giving them more work to do if you leave, didn't give you trouble?
[CL] No. It was only a half hour. Other people take plenty of time off, and I rarely do, and it was for a good reason, and we are on flexitime anyway! So I'm not even leaving *early!* And I had told everyone else in the office the day before. So I was really surprised, when just before I felt, the lady complained about it...and the next morning as well. It didn't really affect her.

Lore reflected on what lay beneath the compulsive and obsessive elements to her desire to 'win,' and to be successful was a need for autonomy and her own authority. This did not mean the loss of competitive feeling, but a different way in which she experienced its goals, and Lore felt more able to choose when to engage in competing with others. First came a keener sense of what her competitive feelings felt like. Next came the ability to withstand the costs. Winning might result in relational inequalities, and others becoming upset, but this became more acceptable in being able to show her competence.

S 9 - 130 APES = 4 L is uncensored by *Child* for being potentially 'nasty' or aggressive, and accepts both feelings and expression
L has just been describing competitiveness with her lady co-workers in her office, regarding work and sexual attractiveness.
[CL] I feel like she and I are in competition sometimes.....but then I feel competitive with all the other secretaries....you know.
[T] What kinds of goals are you competing for, in your mind?
[CL] Ah, everything really.....[ ] (*smiles, sleepily*)
(*L's stomach begins to rumble)*
[T] You're stomach is trying to say something right now.....
[CL] (*laughing*) It is cheering.
[T] Cheering you on....like getting excited?
[CL] It isn't a bad feeling....it is lighter, above the pain.

This shift also meant relaxing some of her earlier attitudes. What had been split off earlier as manipulative or selfish impulses or actions could begin to be owned as her own, *viable* actions or intentions. In this process, Lore became better able to listen to her body's needs and become more nurturing to herself.

s12 – 700 APES – 5 *IndA* expresses self easily without force, and is applied to a specific situation where she needs something to feel better. In reviewing and contrasting now with past, she is offering understanding to *Child*-dominant Lore. Still not quite confident, but making progress.
[Cl] Yeah. I feel more that way. On Saturday, I am going for a facial, to work on these angry spots (*blemishes on her face*), because I don't want to have to go and have my face all bad, and sore....I mean I would be okay without it, but I want to give myself some help...and feel better about the way I look.
[T] So you can treat yourself, before going on holiday....relax and treat yourself...
[Cl] Where I used to feel guilty if I did that.
[T] Any twinges?
[Cl] Just a few. I realise....I should listen to what my body is saying..... but I realise that I just usually battle on, and don't listen to what my body is saying, and now it is saying it needs to relax and get special help.....but I still have to overcome the guilt side, but it isn't so hard. I have almost overcome that feeling....
[T] Sounds good! You don't go overboard, you just give more to yourself, a little.
[Cl] (*smiling*) Gradually!
[T] Fine, and that is a good way. This is exciting, because it feels like real giving to yourself.

These examples demonstrate that the shift made from late level 2 to level 4 expression of *IndA*. In part, it involved the freedom and ease with which Lore

could identify her own concerns or responses and express them, even when they were ambivalent, or when interpersonal circumstances (both external to the session, and within the therapeutic relationship) made finding appropriate forms for these expressions difficult.

12. *Child* and *IndA* return to struggle again

Lore still returned to a struggle between *Child* and *IndA* at times, especially when she felt vulnerable again and uncertain of her own and others' feelings.

s 12 - 045 APES = 3 Struggle is experienced as intense; anger for both *IndA* and more symbolically for *Child*, however L associates easily to this voice. L is aware of *IndA* comes out in her response to her 'teen-age' face, with anger; also in counterdependency in relation to fiance and workmates.. From *Child*, reasons for keeping it dominant, although some are rationalised.

L complains of having facial spots (pimples) which mark her appearance, just before holiday.

[T] So what would you like to say to your spots?
[CL] Just, go away and don't come back.
[T] Go away and don't come back.
[CL] I feel I'm old enough now that I don't really have to have spots, I'm not a teenager! You know .....so.
[T] It's a way that your body is almost saying..... I still feel like a teenager.
[CL] Yeah. mm hmm.
[T] Let's just see where we are going ..... Your body is angry.....and you're angry with your body.....at least part of you doesn't agree with it..... I'll talk to the other part for a minute, the part of you that *angry* and *still feels like a teen-ager.* Is it possible for you to feel that part?
[CL] Yes I can. Certain aspects.....ah..... you don't actually want to grow up in a way.
[T] I'm remembering when you said this, something like this before.
[CL] That's what I said, yeah it's like you don't want to get any older, you're happy in the way you were. Because you have to *face* things, quite, you know. Quite a lot of pressure and change...you know, that kind of thing.... when you're old...but when you're a teenager, you're very care free, you don't have anything to worry about. So that .....kind of side.
[T] When you were talking about this before, do you remember what you were talking about...+
(Cl] + I think, the fact you are breaking free.....um....from where I live, it's a sort of ...*nest.* You know, you've obviously...uh...got to spread your wings! (*said with kind of rhetorical ring*] Etcetera. That kind of thing. [ ]
[T] Except, you won't exactly be living on your own.....
(Cl] (*pause*) Em.....well, I would....I do *hope* to be moving in with my fiancé (*factual voice, logical but tense*) ....so I wouldn't be on my *own*, but....he's the same as me....sort of, very much a learning curve....well, he's never moved out before, so....
[T] Am I right in hearing, that of the two of you.....you end up more .....often, taking the leadership role...
(Cl] Yes, uh-huh. (*strongly*) That is me....like, what I do at work.....it is that (*my*)....that kind of nature.....
[T] So..... in some ways, it *would* be.....more like you are on your own.....you are having to do more, than somebody else....+
(Cl] +Yes. Yes, that's right. I will take more of the responsibilities.
(*pause*)

Another example where a conflict re-appeared concerned her work. As advancement within her council was slow, Lore began to look for new job opportunities outside her agency in order to improve her prospects, re-activated

concerns over separation arose. Her responses to these feelings were initially so strong, at times they shifted her focus back to waiting to move up within her own office, and thinking about material acquisitions, and sudden shopping sprees. Her therapist was vaguely aware at this time there might be other incipient issues arising, although their identity was not discussed until later.

6. 4. 6. 4 Impact of integrating *IndA* into self community

13. Making a link between new emergences of conflict and somatic symptoms

As she worked with the struggle between *Child* and *IndA*, a new restlessness occurred during the second half of her therapy that was accompanied by new somatic symptoms. Occasional and brief feelings of claustrophobia, or sudden feelings of isolation or stuckness came upon her. Her therapist tentatively interpreted these experiences as coming from an increased feeling sense of *IndA*, who was feeling its restraints in some domains and desired more expression.

Occasionally these moments were perceived as a threat to her sense of security, and she considered that they resulted from her recent attempt to rebalance decision-making within herself. She recognised that she was experiencing an increase in her dissatisfaction with outer interpersonal roles she was still taking, and began to notice a link between these feeling and developing new, vague somatic complaints, such as feeling diffusely ill, or nauseous.

s 11 – 558 APES = 3 Makes link between current experience and developmental experiences of feeling incompetent, and unnerved by it. Expresses desire to change.
L is talking about cutting remarks made by the director of her organisation to her.
[CL] He asked my co-worker if it this meant I was nervy, and said it was dirty (*L is speaking about her scalp psoriasis which was noticed and loudly commented on by the director)* This does remind me of growing up, being bullied and hearing how ugly I was. It made me stay indoors; I was afraid of going outside.
[T] You haven't had enough experience somehow.....hearing how special you are, how much you are valued by others...instead you hear something about you is wrong or dirty....
[CL] No, I haven't. You wouldn't believe the difference from yesterday, when I was feeling up and nothing bad was happening at all. I mean, I haven't gotten completely down, and I feel okay, just not as up as before....and all because of coming into work and getting hit with this remark. I need a change!

Being aware of this link, enabled Lore to *think* more actively about it, and re-consider how she might develop a different resource that would not become so easily threatened.

s11- 135 APES = 4 Having applied a solution recently, with partial success, L realises capacity of focusing on self and action independent of others' wishes. She has made a meaning bridge: she can be both imperfect and caring, and assertive.
[T] You seem to be speaking with a new more confident voice....today; not a new voice maybe, but one with a different emphasis.
[CL] No. Yes. It feels new.
[T] It's like, going early to go to hospital that day, and not being concerned with your perfect time record....or being too fluffed when you were wrongly criticized for doing so.
[CL] Yeah. Well, I think.....that is what I've been doing wrong..... I haven't been thinking of myself, enough.....you know....I feel I've been always putting others...first. Which is.....they way I was.
[T] Hm, and you....liked being that way.
[CL] Yes, but I can be assertive, too...
[T] So maybe your changing.....is having an effect on others....which at the moment isn't so positive.....but what is interesting is that doesn't make you go back to the way you were before.
[CL] No. Uh-uh.

Lore could own her need for power and autonomy without guilt, and with much less anxiety. Her capacity to self-nurture when her anxiety did start to escalate improved, rather than retreating into her *Child* voice and demanding special care from others, or finding that she fell ill. This did not mean *Child* was abandoned. When she realised she wanted to end her relationship with her fiancé, she permitted her dependency on others without losing her *Independent Adult* voice.

Becoming more aware of her dissatisfaction with other relationships was likely to have affected her perceptions of subsequent events involving her fiancé. Feeling a lack of reciprocity in this relationship had been hinted at earlier, although these occurred as half-finished sentences, other parapraxes (e.g. slips of the tongue), or single utterances, which were disclaimed later. Following her break-up with her fiancé, she reflected on the shift in her own response.

s13 - 084 APES = early 3 Past bid for independent status (counter-dependent and mothering others a way of *fighting against* dominance of desire to merge) is not working any more. Realises wants more reciprocal care. Some back and forth movement
L has contrasted her own action (breaking up unsatisfactory relationship) with proverbial others who just go on, unhappy (a contrast which fits her earlier, pre-decision state).
[T] Let things decide what to do, instead of your happiness and feelings tell you what you should do.....
[Cl] Uh-huh. I couldn't go on being unhappy, with him.
[T] I get the feeling.....it's like.....you cared for him.....in ways that.....it's like, you saw a lot of yourself in him earlier.....it was like, you being able to care for yourself.....your old self by caring for him.....does it make sense?
[Cl] Yes, it does. Uh-hm.
[T] And now.....could it be, you are ready to want something more.....you want something back, when you care for someone.....
[Cl] Yeah, I feel that.....I'm not trying to be unkind, but I feel that.....I don't always want to be the one that looks after things. I want someone who will look after *me*!

14. Further excavation of voice history and development of meaning bridge

Indicative of a rating of Level 4 was an understanding of how *IndA* had become suppressed at such an early stage of its development. Lore talked about her realisation that when she was bullied as a young child, a *'part of her had gone into hiding, within.'*

s16 - 176 APES = 4 Although can't quite name it, L owns resource that gives her a basic strength to use even adverse experiences to her advantage. Greater sensing of self-reliance and seeks to articulate it.
L is musing about how she feels stronger, and has gained even through rough times.
[T] So even though you have had a rough six months, in several ways.....you went on those two job interviews, really wanting the jobs, and missed them both.....up and down with your health....missed your holiday you saved for and then the ending of your relationship....your friends getting things they want, and you feeling left behind.....and yet, you feel you have gained something .....important..
[CL] I have grown.....I just can't quite say how yet.....quite a few people have said to me, if they had been in my situation, it would have been worse....stayed off their work, and things.....so I must have some.....mechanism for.....coping...
[T] But it isn't your cheeriness.....
[CL] No
[T] but some other resource within you.....
[CL] It's in me, yes.

When she separated from her fiancé, it did not feel so overwhelming, in spite of being painful. Lore used this time to review her own feelings from past and present. She continued to talk about her sense of this review and the ambivalence it brought at termination. While she recognised that she was experiencing depressive symptoms, she did not want to be 'relieved' of her sadness and the psychological pain that came from some reflections. To her these feelings were real, and part of the growing process that she felt was occurring.

6. 4. 7 Comparison of voice sets

Of the voices selected for this analysis, *ACE* was believed to be most dominant, or present and central to Lore's ego functioning more often than the other voices heard and analysed. It also provided a viewpoint from which evidence of other voices was offered. Lore identified with her cheerful *ACE* voice, and alternated between her ambitious striving for adult success and independence and her child-like self. Making a positive impression and maintaining a check on impression

management remained key foci in her attention during the first few sessions, and this energy appeared to carry over from how she lived and worked and related outside of the therapy. For *IF- ACE, Lore's* movement between levels 1 – 3 was uneven. Although she showed clear movement between early and later sessions, her progress zigzagged back and forth between *IF* emergence and a re-assertion of *ACE* dominance within the two domains which dominated her narratives: her work performance and desire for achievement, and her relationships with family and fiancé.

Her *Independent Adult (IndA)* voice, although clearly somewhat emerged, was overshadowed by a more dominant *Child.* She was conscious of and could articulate these qualities and goals for herself, but was less able to understand the nature of the needs and impulses that underlay them. Nor could she see that they interfered with *IndA* expression at critical times (i.e. their conflict was avoided as they spoke at different times and appeared to exist in a kind of *split* in Lore's community).

An angry critic or *Bully* voice also existed as a deeper voice, one that was believed to be repressed primarily by *ACE's* conflict with *IF*, although it also offered reasons why Lore would not be able to function sufficiently as an adult, if *IndA* were allowed a more prominent role in her personality. Equally important was her lack of understanding that conflicts underlay the problematic experiences she kept encountering, including her repeated experiences of disabling physical pain and other IBS symptoms, and repeated experiences of anger and hurt arising from interpersonal conflict that fuelled depressed affect and appeared to block further development of her self-concept.

Thus, both a clearly dominant voice and a conflict already in emergence represented aspects of Lore that offered beliefs and views about the nature of her problems initially. Her own physical pain was to be hidden, never shown, and caused *ACE* a significant amount of distress, although this voice refused to be stopped by pain, no matter how severe. *Child* was better able to experience fear more directly, and this was a primary motive for keeping in a dependent role and not creating possible frustration or opposition with others. Initially *IndA* was obstructed by her pain episodes most of all; the distress and disability she

experienced during episodes prevented Lore from acting and thinking in a forward moving way, and left her wanting to take to her bed and become unconscious. The

therapist heard this in a symbolic way, as the struggle for individuation was tiring and demanded heavy emotional costs for Lore, who at times must have wanted to give up the struggle altogether; indeed it was her own inner *IndA* and *IF* that would not let her do so.

6. 5. Pain Analogue Analysis

Sixty comments were found in which Lore referred to a pain experience (or a period of time in which she was completely pain –free). The majority of these referred to recent and specific episodes of pain (within the previous 6 days). These episodes accounted for two-thirds of the total comments made; others referred to non-specific episodes or references to her history of pain. Seventy –five per cent of these comments were contained in therapy segments involving reference to one or more voices, and also received an APES. The other twenty-five per cent were segments of transcript in which pain was mentioned, but sufficient evidence for the presence of a voice under study was lacking. The majority of pain-related segments belonged to the *ACE- IF* voice set (31 out of 45), *Child – IndA* contained nine, and *Bully – modified Child* voices had only three segments associated with pain, so a comparison of ratings between voices was not useful in this case.

6. 5. 1 Relationship between APES ratings and pain ratings

Eighty-three per cent of Lore's pain comments were given pain ratings. The following scale (Table 6. 6) was constructed based on the range of her overall comments about pain and their qualities of type and intensity. It can be noted that these bear a structural similarity to descriptions associated with Megan's pain levels, although the percentages of comments within each level are different.

When all segments that had received a pain and an APES rating were analysed (n = 34), a significant negative correlation (Spearman's – .3905 $p < .000$) was found. When the pain comments were clustered in each of the APES categories, 17 out of the 19 pain ratings of 3 or higher (bothersome, beginning to interfere with activity and creates intrusive stress) were associated with APES levels 0 – 2. By level 2.5, where a conflict was recognised, even though Lore felt unable to change it, her pain began changing in quality as well as reducing in severity, and her comments were more likely to spontaneously include ways in which she offered herself care and nurturance. At level 4, her comments offered psychological insight into inner states, which had caused pain in the past, and might still create headache, or sore acne or toothache. Her gut pain had disappeared by this time.

Level	Lore's Pain Descriptors	*f*	% Tot
0	No noticeable pain	9	15. 0
1	'Small' discomfort: new discomfort but does not provoke worry	5	8. 3
2	Slight bloating or occasional niggling or aching pain; doesn't interfere with concentration or activity.	9	15. 0
3	Crampy pain (IBS or period); bothersome and threatens to impair performance; intrudes	9	15. 0
4	Strong pain, but not necessarily lasting. Associated with worry, and difficulty in persisting with activity	11	18. 3
5	Severe pain, lasting. Disabling and must eventually cease activity	7	11. 7
	No pain rating given. **Missing**	10	16.7
	Total	60	100.0

Table 6. 6 Pain levels and descriptors used to rate Lore's pain comments and per cent of comments in each category

6. 5. 2 Functions of pain comments

Four main functions were identified for Lore's pain comments (*see Box 6.2*). One occurred frequently at the beginning of her work, when she talked about the threats imposed by real or feared pain. The primary impact feared was social distress; either her pain would change her behaviour or capabilities and render her embarrassingly weak or unable, or it would make her ugly and distasteful in some way. Much of her talk *about* these threats appeared to be anticipatory. Like other statements of worry, they could be hypothesized to prepare her against

1. **Impacts on function and social relatedness described.**
2. **Episodes of pain compared, in order to assess need for vigilance.**
3. **Making decisions on how well I am coping.**
4. **Use sensations and pain to consider own needs and responses to situations**

Box 6.2 Types of pain comments categorised by function (Lore)

the unknown, or intolerable shock. A second function seemed to involve comparison. Lore would experience pain and in parallel measure this experience with previous ones; if it was less painful, she was hopeful. In this way, pain seemed to act as a mode of evaluation of *self*, in a way similar to an emotional

response. The comparisons also provided a basis on which Lore could decide to approach or avoid: what was safe to plan or attempt? When did she need to worry about risking further pain or failing to complete her task at hand? A major component of these functions was cognitive; the pain itself was an unpleasant distress, but the energy and content of her pain narratives revealed its complex connection with her state of anxiety.

Another function involved her review of her own coping, including her emotional responses to pain. Finally, as Lore began to use her therapy to help her explore her pain in relation to other kinds of experiencing, she spontaneously registered the sensory feelings and related her associations to these experiences. She discovered that her pain became a signal to stop, and *sense in*, and the pain itself appeared to take on qualities associated with tension, anger, and the push-pull of inner conflict. This level of experiencing was enough to connect Lore's conscious thinking to other associations (e.g. times when she had experienced similar, but non-pain associations) and with assistance consider how these might represent more inner states.

6. 5. 3 Associations accompanying pain comments, and changes over time

An examination of all pain segments that received a rating (n = 50) showed that as the pain ratings increased, the comments became more dramatic as well as negative, as would be expected. At a pain rating level of 5, Lore felt overwhelmed, both in current experience and memory for a specific pain episode. At level 4, there was the desire to avoid or blot it out. Level 2 appeared to be a pivotal category; Lore experienced her body as potentially shifting *in* or *out* of alliance with her needs or threatening to become an enemy. At this level she experienced new illness symptoms as well; her therapist wondered if this were metaphoric for her becoming more sensate, generally, to different parts of her body. Level 1 was associated with more awareness and linking with emotional states or stressful situations, and level 0 was associated with relief or lightness and power, as well as links between her physical and psychological states.

The results from the APES analysis were partially supported by examining the associations occurring between the lower and higher ends of the pain rating

categories. At pain rating levels 4 and 5, her responses and associations were more avoidant, briskly denying the importance of bodily signals or focusing on the importance of her *ACE* self. She could however relate a fear that her pain would create disability; this in turn would reduce the good opinion others had of her. Lore was more focused on changes and perceiving her own emotional reactions when her pain rating existed at levels 0 and 1, even when these were affectively negative in value. With the knowledge of these links came a better sense of control. She more spontaneously began to look at the way interpersonal events were affecting her.

During session 8, Lore was beginning to grasp her conflicts over realising her competency and demonstrate her ability, fearing the impacts this would have on her enmeshed attachments. Her fears were readily associated to earlier experiences she had growing up and feeling bullied by peers or rejected by family. Stronger feelings, such as rage and depressive emptiness were experienced with some discomfort, but pain was not present.

By session 14, Lore's discussion about her experience of pain was no longer somatically based; she was talking about the psychic pain she felt over the loss of her relationship, the disregard she sometimes felt from well-meaning but unempathic others, and the store of feelings within containing her prior experiences with fear of disapproval and failure. This pain appeared to be more manageable if not under her control; she could move with it, rather than feel stuck by it. She was fee to contemplate other passing thoughts and feelings and interactions with others, to consider their relationship to her distress. Thus, psychological pain could become a portal through which she could review her own actions and decisions, and her relationship with others. Unlike her experiences of somatic pain, it could be talked to, and argued with; even if it remained Lore was beginning to find ways to bring succour to herself. This paralleled the change in her ability to self-nurture when she was tired or ailing.

Her original pain episodes had stopped at the end of therapy; however she had become clinically depressed as well. Lore attributed both events to a single cause: she was evaluating her relationships differently, and making clearer, albeit painful decisions regarding how she wanted to live. Her depressed affect was experienced

by both her and her therapist as a replacement for her somatic abdominal pain. Lore offered during her six month follow-up session that she did link these two events, and felt her depression was a better symptom for her to live with, as a portal for further work in identifying and accepting the pain of loss as well as her own self-needs.

s18 Follow up
[CL] Now I finally know what is bothering me……I prefer this. It is more real!

6. 6 Integration of case analyses

In this section, an integration of findings from the four analyses (i.e. the psychometric analyses, the psychotherapeutic formulation of dynamics and their movement, the assimilation analysis, and the pain analogue analysis) will be presented, in order to achieve a convergent picture and explore how together they may help the understanding of Lore's dynamics and her movement in therapy

The psychodynamic concepts of attachment and narcissism helped to explain often conflicting aspects of Lore's presentation, and the development of her *imbalanced self- community,* as exhibited by the lack of assimilation of two key voices. Her high SUIP score indicated a concern with and dependency on other's approval. The assimilation analysis extended this conceptualisation further and described different (and often fragmented) aspects of Lore's experiencing at the start of therapy, with their changes across sessions. The psychometric measures helped to emphasize different aspects to her presentation and beliefs, and her tendency to repress psychological distress and keep herself identified with strength and stoicism. Finally, the pain analogue analysis helped to offer explanation to the role taken by Lore's pain experiences in her self-regulation of anxiety and distress.

6. 6. 1 Matrices of understanding provided by separate analyses

Her therapist and supervisor hypothesized that Lore's attachment to her family and friends was ambivalent (i.e. as expressed by her restless desire to have more control over her life and lifestyle, on the one hand, and her intense devotion and fear of separation, on the other). Her fear of separation was a major motivation in supporting a dominant *Child* voice and inhibiting *IndA*'s development. *Child* was conscious of a strong need to keep others close, and her own behaviour within fairly rigid boundaries. Similarly, this need and fear indirectly supported her *ACE* voice (i.e. as it was for the most part pleasing and helpful to others). This conceptualisation was also supported by the psychometric measures reflecting Lore's distress, and some of the changes that occurred over her therapy. First her classification as moderately anxious *and* defensive indicated that she was aware of chronic anxiety at least some of the time. Lore expressed concerns about the quality and moral fibre of her interactions with other people, and indicated that she experienced distress regarding her interpersonal relationships (e.g. she was symptomatic with clinically significant scores on the CORE, BDI, BAI, and

indicated a high number of interpersonal concerns on the SUIP). These concerns competed with her worries about her pain and its impacts from time to time. In addition, although these scales could not indicate whether she felt her physical and psychological symptoms to be the cause of her concerns about social and occupational functioning (or alternatively, whether her latter concerns were the cause of her symptoms), together they provided an associated matrix of distress and worry for Lore at baseline.

Her IPQ item scores indicated that she had a vague awareness that her cognitions and way of coping with distress did probably contribute to her physical symptoms, and vice versa. The matrix of associations between physical symptoms and her fear of a reduced ability to be active and pursue her life goals was also strong. Nonetheless, there were still aspects of her symptoms that were mysterious to her.

These findings stood in contrast to initial self-presentation achieved at intake or in the early sessions, as indicated by the psychotherapeutic formulation and case review. Aside from her current worries and desire to be more active in her own recovery, Lore presented herself as bright, articulate, and cheerful, robust with good feeling about her life and herself, albeit nervous and expressing some anxiety. Thus, the genesis and maintenance of these dominant voices could be seen to serve two defensive functions: Lore did believe that the regular expression of these voices would make her agreeable and worthy of respect or approval, and would also keep her own fears of disorder and chaotic behaviour at bay. At a deeper, less conscious level, however, Lore appeared to fear that her own psychic integrity could not maintain, on her own. This paralleled her repeated experience of lacking sufficient boundaries in her interpersonal relationships as well.

6. 6. 2 Dominant voices as defenses against conflict

The dominant voices were easily identifiable aspects of Lore's personality; similar to Reich's (1949) theory of character armour, they were revealed in various aspects of vocal tone, body posture, attitudes, expressed strivings and mannerisms. For Lore as well, they represented important points of identity. They also appeared to offer a system of defense against experiences of painful or overwhelming anxiety, and a protection against outer, or social difficulties. Thus, *ACE* represented a *liked*

part of her identity (a likeable and functional personality), *a defense* (avoiding painful awareness of competing impulses revealing disaffected or aggressive responses) and a *social persona* (i.e. it helped her focus on impression management and therefore maintain acceptability to others). Her feelings about *Child* were somewhat more ambivalent, as *IndA* was partially emerged at the start of therapy, and offered a future *self* that she could identify with, albeit in an idealised and potentially unrealistic way.

Lore was not aware of the inner conflicts these defensive voices masked. Her attitudes towards self-presentation and coping were not consciously connected to problematic experiences encountered. These included her repeated experiences of disabling physical pain and other IBS symptoms, and repeated experiences of anger and personal hurt from interpersonal conflict, that fuelled depressed affect and inhibited the further development of her self-concept.

The relatively warded off voices or objects that represented instinctive feelings regardless of their social acceptability, or her capacity to function as an independent adult could also be viewed as narcissistic injuries. Features of narcissism have been shown to include restriction of emotional affect, lack of understanding of *self* needs, the hunger for mirroring, boundary problems in interpersonal relationships, grandiosity, depression, and perfectionism (Kohut, 1977). Narcissistic individuals have not been able to adequately develop a consistent sense of self, without the constant internalisation of input from others, and self-esteem can rise and fall greatly, depending on the feedback received. Although narcissistic needs for recognition and positive regard from others is a healthy and necessary part of relating, narcissistically-*disordered* individuals suffer significant shifts in their states of mind depending on the degree to which their self-esteem has been re-fuelled by recent regard from others. Winnicott (1976: 1960) offered a similar perspective in describing the holding phase in which the mother needs to be able to accept the child's dependency on her for a sense of reality. The mother or primary caregiver needs to adapt to the child's needs in a way that offers respect and appreciation for the child's unique needs. When the mother has narcissistic injuries of her own, she may use the infant to satisfy her own needs. Narcissistically- disturbed mothers' or parents' own problems with self-esteem and depression do not permit them to offer a degree of flexibility in understanding their

children's needs, and consequently the child begins to carry their caretakers' emotional needs. As a consequence, it can be very difficult for the narcissistic individual to know their true feelings, as their accommodating self assists their emotional survival. This neglect of their feeling-based *self* may result in either depression or grandiosity as defenses against isolation and abandonment feelings, and inability to acknowledge relationship problems.

A logical consequence to this continuous need for definition by others would be that they are more prone to introjecting others' unevaluated projections. Distinctions and reality –testing between *self* and other would thus become problematic, as the essential boundaries for these processes are lacking. This helps explain why Lore needed a constancy of input from others around her, but also found her feeling like a *magnet* at times. Her own interpersonal boundaries were variable. Her experience of her own unassimilated voices, *IndA* and *IF* were partial, fleeting, or contained distortions (e.g. affected by *Child*'s anxieties), necessitating an orientation towards successful others in order to measure, and perhaps in some way, even *experience* herself.

Compared to Megan, Lore's distress was less focused on her pain but she did experience it as a chronic impediment to her functioning and her ability to see herself as competent and attractive. Her Pain Grade was II, and the severity she periodically suffered was high (70.0 on CPGQ, with a total score of 15 on the PSS, and mean score of 5.92 on the CSFBD). Her pain symptoms had changed by the end of therapy (e.g. Her CPGQ had reduced to 56.7; PSS reduced to 6; and mean CSFBD decreased to 5.40). At the start of therapy, her *ACE* voice dictated that physical pain was to be resisted, if possible. It was important never to show this weakness, and both the pain and her worry about its impairment caused Lore a significant amount of distress.

6. 6. 3 Analysis of change

IF provided a closer connection for her symptoms and their meaning; once allowed to emerge and express itself with sustained attention, this voice offered immediate links between her physical pain and other symptoms and Lore's emotional experiences which otherwise might be occluded or denied altogether. Initially the

boundaries between Lore's *Bully* voice and *IF* were not clear. Both offered strong *feelings* and appeared to be related to more primitive *instincts.* However, *Bully's* needs were more singular if not less impulsive; she was motivated by frustrated rage and a need to hurt anyone (including other voices within) who got in the way of her needs for power and revenge. Developmentally, her aggression represented an immature and impulse-driven level of self-assertion. Just as a baby's response to frustration initially betrays a belief in its omnipotence, Lore's primitive power to judge events as good or bad depending on how well they provided satisfaction and esteem remained in this split off aspect of herself.

Allowing a more feeling-orientated *IF* to express herself brought a realisation of deeper connections between her feelings and fears and pain. In addition, her consciously accepted experiences with her own frustrated anger, hostility and fear of overwhelming loss helped Lore make a connection between inner feelings and the behaviour or others as well as further inner connections between these feelings and her own frustrated needs and perceptions of the reality of others. The further contiguity between accepting these *ugly* feelings and what they told her, and the cessation of her continuous nagging pain further helped her realise that pain itself was consonant with the denial or *splitting off* of these feelings on another level. Both the correlation of conflict assimilation with pain level, and the qualitative aspects of her pain narratives supported this link for her therapist as well.
This was a gradual process, however, that appeared to be composed of several smaller processes, which corresponded to assimilation levels 1 and 2. For the assimilation of both emergent voices, these included an increase in the degree to which Lore was aware of these voices and their identity within a larger community of voices within herself, and her ability to express them when she chose. A decrease in the automatic control taken by the previously dominant voices (*ACE* and *Child*) was observed, and an ability to reflect on these voices from the perspective of a (potentially) conflicting voice.

Some of the processes described in these movements were similar for these voices. These included a period in which her emergent voices intruded, and were followed by a re-assertion of dominance by *ACE* or *Child.* These processes could be interpreted and reflected on by both therapist and client. As these emergent voices grew stronger, other processes occurred in which the dominant voices could be

viewed more objectively (i.e. with less identification), and their limitations or negative consequences realised. Helping Lore perceive the existence of her newly identified emergent voice in more than one domain may have helped her make other links which enabled her to test her understanding of the qualities of each voice, and finally understand the conflict between opposing emergent-dominant voice pairs (level 3 assimilation). Struggling with this conflict brought a reduction of anxiety and released energy. New experiences and continued reflection brought eventual insights (level 4) about the historical reasons leading to the establishment of dominant voices for Lore.

Finally, for her newly exercised *IndA* and *IF* voices, Lore was beginning to use her understanding and apply it to interpersonal situations (level 5) by the time therapy ended. These changes brought further changes in Lore's relationship to these voices. As her understanding for their history and factors which influenced their relative dominance or repression increased, she was able to accept her own ambivalence over the loss of familiar albeit problematic ways of thinking and responding, and the acquisition of new ways not yet tested in her outer relationships with others. Both previously problematic and dominant voices changed in quality. Emergent voices needed to be heard in their complexity as Lore related to life situations. Dominant voices did not just lessen in the frequency of their voicing, but they also softened as their role in defending Lore against pain and anxiety also changed. Initial gains here were made in her workplace, a domain where Lore had indicated the most frequent intrusion of *IndA*. As she began to gain greater access to her feelings, she spontaneously began to develop greater insight into the interpersonal and intrapersonal issues that arose with her co-worker, and could better separate the two. This enabled her to better acknowledge and accept her own anger and irritation towards this lady with less fear and dread of her own guilt. More generally, Lore appeared more spontaneous and alive in these sessions, and her speaking voice deepened in tone. Other areas in which she could recognise if not always actively assert her preferences included leisure activity, social engagement, and clothes.

As Lore released her reliance on *ACE's* dominance, and she was better able to express her assimilating *IndA* voice in all its uncertainty, *Bully* was better able to emerge and provide an attack from the inside. This voice within Lore's personality

was also believed by her therapist to be related to her masked depression. It was still emerging at the end of her sessions, in the form of periods of self-doubt, grief over the loss of her fiancé (and the previous dream of an ideal). For a while Lore could not hold onto sources of good esteem and memory. Yet she was able to withstand these periods by her own admission; she felt that although she was depressed, she was somehow *stronger* with it (i.e. she could tolerate these bleak periods without feeling dangerously low or frightened of disintegrating altogether). She recognised that she had gained something inside of herself, that allowed her to evaluate people and situations – and herself – differently, even if it brought pain of a different kind. Most importantly, she was better at understanding what her feelings *meant*. Her depression had much to do with the fact that she was letting go something that had been important to her in the past; it involved more than ending her relationship with her fiancé, and she needed a time to grieve and be with herself. Lore knew she had more work to do, but also chose to use the next period of time to consolidate her recent learning.

By the end of therapy her experience of pain had reduced in both quantity and quality across pain measures. Although there was some indication that when she did experience pain, its effects on her functioning were the same, she was overall less concerned with the impacts of her GI symptoms on her ability to plan for her future and cope with them (CSFBDQ). She felt her quality of life had increased significantly by the end of therapy. In addition, at outcome her presentation was more consonant with her self-report scales (i.e. she embodied in less defended way the way that she felt).

Otherwise, her increase in psychological symptoms and her awareness of their cause corresponded to a consistent decrease in her pain symptoms as she reported them. Both of these results might be taken to support the idea that her experience of pain and other IBS-type symptoms may have related to an underlying depressive disorder rather than an underlying functional pain disorder. This would also explain her seemingly contradictory and continued classification of her chronic pain grade of II (describing low disability and high pain intensity). In addition to the fact that her pain grade covered the previous six months (i.e. concomitant with the duration of her therapy), and therefore might not reveal a substantial reduction in pain during the last eight weeks of her therapy, it might also express her

responsiveness to continued somatic expressions, and affective experience as somatic symptoms as well. Indeed, therapy notes and her assimilation analyses showed that Lore was developing more awareness of her affective experience even at the end of her therapy.

Lore also felt she was finally facing what she feared most: being alone and feeling loss. She considered that she might not find a primary love relationship and that her dream of an idealised future might not be achieved. Accepting herself in a greater and more embodied totality allowed her to live in her current reality differently; she was risking a sense of further loss and failure by relinquishing her hold on perfected views of self—and others. Yet she found she preferred this reality, and felt more secure in it. Albeit she was still suffering, she '*had something she could work on*,' unlike her previous attacks of somatic pain.

CHAPTER 7 SUMMARY AND DISCUSSION

In the discussion that follows, conclusions will be drawn from these studies regarding the applicability of their findings to the original research questions posed. Methodological issues pertaining to the validity and robustness of findings and the use of case studies will next be discussed. Finally, the implications of these findings for future research and practice will be addressed, along with emergent themes relevant to developing further theory about the psychosomatic expression of disorder exemplified by patients with chronic gastrointestinal symptoms.

7. 1 Summary

These analyses have revealed findings relevant to the conceptualization of psychosomatic illness, and important aspects of psychotherapy with clients concerned primarily with somatic suffering and disability.

Intricate relationships between the existence of unconscious conflicts were revealed, along with the use of fairly fixed defensive strategies, which underlay continuing gastrointestinal illness experiences. These conflicts were pervasive in these clients' lives, but not always *active*, or stimulated by current situations or interpersonal encounters. In particular, severe and disabling pain episodes were associated with the active but unconscious avoiding of these conflicts when they became stimulated. As the previous conflict regulation defended against knowing, they created an imbalance within the psyche (i.e. there was a lack of freedom of movement into awareness), and therefore clients could only be aware of some aspects of their own processes (Gill, 1963). Finally, these dynamics between inner structures or voices were found to reflect more chronic deficiencies in self-development (Hingley, 2001).

These studies have also opened up some new avenues for consideration regarding the measurement of therapeutic movement and symptom change. They have highlighted several issues important in the consideration of offering psychotherapy to individuals with functional somatic disorders. Specifically, the value of combining different therapeutic and measurement approaches to formulation and analysis of change processes has been demonstrated.

7. 2 Importance of Case Comparisons

The clients in this study showed important similarities and differences. Both have implications for the potential usefulness of these findings for future research and practice. Lore was a young adult with a shorter chronicity of symptoms, while Megan was middle-aged and had suffered severe pain episodes for a longer period. Both had history of disease-related inflammation that may have served as an origin for their continued episodes of severe pain. Lore perceived her illness as an example of IBS, a disorder she understood she shared with many others, and for which there was some abundance of publicly accessible information. By contrast Megan understood her pain as related to an earlier disease of the gall bladder duct system, although it remained largely mysterious. Both however revealed barely conscious fears that their symptoms might herald a more serious illness. At the start of therapy, Megan was resistant to the idea that psychological factors might affect her health, and her chronic abdominal pain in particular. Lore on the other hand acknowledged that she was anxious and that she tended to experience stress through somatic symptoms generally, although she did not understand what factors were influencing her episodes of abdominal pain. Ample evidence was gathered that both women engaged in compulsive defensive strategies in order to cope with anxiety. Megan and Lore both measured their coping strength in terms of their ability to stay active and perform occupational tasks.

The psychotherapeutic and voice formulation for both women indicated that they had difficulty admitting powerful emotions into experience, and with some work could identify a resistance and fear of loss that might occur if such feelings were realized. For both, these appeared to be associated with earlier experiences with rage and loss. Lore had more ability to admit darker emotions, albeit with accompanying shame or later attempts to partially dissociate from them. Both women lacked adequate ability to self-nurture. When Lore began therapy, her emergent voices were assimilated at a higher level (Level 1-early 2) compared to Megan (Level 0) and Lore's emergent voices were assimilated to a higher level by the end of therapy. Both clients spoke of gains achieved during their therapy, but Lore expressed more readiness to terminate (although she was depressed in relation to a relationship loss, she was working with the knowledge she had gained about herself). In each case, these clients ended therapy with a sense that they still had

psychological work left to do, and that the therapy had opened them to a greater awareness about themselves; instead of causing frustration, re-focusing an identification of problems to the whole of themselves instead of a fragment involving the physical body was useful.

7. 3 Conclusions

7. 3. 1 *Research Question 1* What psychological conflicts exist in clients suffering from functional abdominal pain syndromes?

The first questions that were posed in this investigation were to discover and identify the psychological conflicts present in the functioning of two psychotherapy clients whose primary presentation concerned their somatic distress from functional abdominal symptoms. For these two cases, their content or structure shared similar features, and related to both social and occupational roles. Both revealed entrenched patterns of conflict maintenance with only a partial awareness of the nature of their conflicts at best In addition, the theoretical explanations that could describe their genesis and maintenance were similar even though some aspects of their dynamics were somewhat different. Thus, their inner conflicts shared some similarities even though their surface presentation varied, in terms of how each client talked about her life and relationships and the metaphors implicit in their understanding of their pain and illness symptoms.

For both clients, fundamental conflicts existed regarding self-other boundaries, or how well they were able to focus on their own needs in relation to their interpersonal roles. The therapeutic formulation and case description and assimilation analyses pointed to longer-term problems in managing attachments, the self-regulation of worth or esteem, and tolerating anxiety (or living with chronic anxiety), resulting in interpersonal conflicts as well as inner ones involving the need to attend to others – or others' impressions– feeling opposed to hearing and serving the needs of the *self* (Gilbert, 2002). Both Megan and Lore had some difficulty processing certain emotional states, especially negative and volatile affect.

For example, both Megan and Lore had ongoing problems setting adequate interpersonal boundaries, and conflicts between internal representations of *self* as one who gives to others to please them, and one who can nurture herself. Megan's

Selfless Server and *ME* voices were in direct conflict. Lore's *ACE* and *Child* were both focused *out,* and judged herself in terms of how much she kept her relationships intact and unproblematic, and her *ACE-IF* and *Child-IndA* conflict involved a direct struggle between a self-vs.-other based locus of evaluation. Both clients were hypothesized to have an insecure attachment status believed to relate to the development of these conflicts. As a way of defending against the eruption of these conflicts into conscious life, both revealed a tendency to ignore certain psychological conflicts (although Megan was more extreme in this regard, Lore also defended against seeing her conflict with her own dependency on, and occasional rebellious aggression towards others), and both sought to transform personal conflicts into socially acceptable ones. Self-control was paramount for each client in her management of relationships. While their expression varied, both tried hard to please others and had difficulties being assertive.

In addition to being active, these conflicts were *entrenched* (i.e. they reflected repetitive patterns in different domains). This was well demonstrated in the assimilation analysis, as each client encountered problems at home and at work over time, and could begin to relate these to past as well as present circumstances. Further, these conflicts were related to earlier and significant developmental experiences. Megan's experiences with emotional and sexual abuse, and Lore's pervasive Cinderella role in her family were underlined by a more pervasive lack of mirroring that persisted for both clients well through their teen-age years.

There was also evidence here that for these clients, their conflicts appeared to be embedded in a fairly complex organization, which would also indicate a fairly central and deep (i.e. primitive) location of their conflicts within their organization of functioning. Working with certain conflicts brought up other experiences or aspects of personality (definable as voices) previously warded off, now closer to awareness, and thus more definable and knowable. These more deeply buried voices involved deeper fears, whose identity remained occluded beyond vague feelings of disturbance earlier. Lore's *Bully* emerged as her own voice once she reached Level 3 for both her *ACE* and *Child*-dominated conflicts, although earlier the sound of a sadistic or harshly critical voice could be heard through others, towards Lore. For Megan, a similar fear of her own incompetence and inability to achieve arose once she became successful in struggling with *ME'* s conflict with

Server, although this was not formalised as a voice in this analysis. Thus one function of maintaining a partial solution for certain conflicts may have been their occlusion of other conflicts, which for both Lore and Megan represented more primitive fears about the self and its adequacy. Stiles (1999a) has discussed an interpretation of one case in which three voices were perceived and created a more entrenched conflict involving benevolent feelings towards others versus the self.

Similar findings have been discovered with clients suffering from chronic gastrointestinal symptoms who have revealed active conflicts involving dependency or fears associated with interpersonal loss (Guthrie, 2003; Rothenberg, 2001a; Levitan, 1989b). These characteristics have been noted in other clients expressing somatic symptoms, including pain (Monsen & Havik, 2001), and similar self-other dynamics have been noted as core interpersonal conflicts for chronic pain patients (Pither & Nicholas, 1991). For both clients, a therapeutic task involved developing an awareness of how strongly these voices or inner objects dominated their perceptions and decisions, and what limitations this posed as a result. Another task involved helping these clients access their own impulses, needs and feelings as a basis for establishing a different – and more self-orientated center within themselves.

The perspectives also aided in comparing apparent similarities and differences between clients, to go deeper and establish a fuller picture regarding the ways in which their dynamics converged and diverged. In this way, the psychotherapeutic concepts utilizing dynamic concepts (e.g. Segal, 1985; Anna Freud, 1937) and attachment theory (Dozier, Stovall, & Albus, 1999) were helpful in specifying and deepening the approach offered by the assimilation analyses. As both of these analyses have shown here, managing others' impressions by imposing rigid self-demands to maintain a consistent outer focus appeared to be fundamental in establishing each client's sense of integrity, and safety. When their own transgressions involving inconsistent or unpleasant behaviour initially occurred, both Megan and Lore felt *weak,* unreliable and miserable. Relying on an outward focus (and its inner representations of approval or dislike in response to her own behaviour) also permitted each client to *use* environmental responses to maintain their feelings of worth (Kohut, 1971).

Thinking about these conflicts in assimilation terms alone might overstress their similarity, however, in terms of assuming a uniformity of conflict dynamics and their change as defined by the model. Psychodynamic theory could offer a different explanatory framework into which aspects of the assimilation model could be considered. In terms of the conflict between a focus on self-or-other described above, Lore's *preoccupied* attachment appeared to reflect a lack of self-development which could provide a locus for evaluation, and permit her to perceive events – including others' behaviour – in terms of her own needs. This hypothesis fit with her experiences of merging with others during times of emotional stress. Megan's conflict involving her *ME* voice was better described by a different type of explanation – one which reflected a more *fearful* attachment style (Bartholomew & Horowitz, 1991). Although *ME* was often denied access to awareness early on, when she was allowed to speak, she could articulate knowledge about her choices, beliefs, and desires, in contrast to Lore's experiences of dissociation or empty blankness where images and words did not exist. Lore's *IndA* voice, when she began speaking for longer periods of time, still mimicked the perspectives and phrases that had been given to her by others, perhaps as a first step of experiencing herself from a different centre than one still merged with other's expectations.

Another caution should be heeded against an over-generalisation of these findings. Ultimately these are only two cases, and hypotheses derived from their similarities – or differences – should only be offered as future research questions. Not all cases of insecure attachment or narcissism develop somatic disorders, nor have a significant proportion of functional abdominal syndrome cases been shown to reveal chronic interpersonal conflicts involving dependency or self-other boundaries. Clearly factors are involved which mediate either form of distress. One suggestion here is that the entrenchment or the pervasiveness of the psychological conflict (due to its formation early enough in development, or the depth of emotional trauma at any time), in conjunction with the rigid use of defenses that prevent movement may be key influences in somatic symptom formation. These ideas have been reiterated elsewhere as well (Read, 1999), and hark back to early clinical inquiry involving psychoanalytic concepts applied to medical patients (Freud 1905:1953).

7. 3. 2 *Research Question 2* To what degree are clients aware of these conflicts and how do they respond to them?

Both Lore and Megan were largely unaware of the nature of their conflicts, or to a large degree, their problematic voices or inner objects. Megan could report vague memories of others telling her that she paid too little attention to herself – or alternatively, as a teen-ager – that her assertiveness rendered her advanced for her age and culture. Yet by adulthood, she herself had little awareness of *ME* or *Feeling One* as current parts of herself, or as anything other than undesirable and problematic experiences. Further, their conflict with other inner voices or objects was not understood. Lore was more aware of her desire to become adult, and that it conflicted with her desire to remain dependent, but her difficulty in managing this conflict was reflected in the lack of strength of her *Independent Adult* voice; it was not developed enough to offer a genuine centre for self-evaluation and choice.

To a large degree, the lack of awareness appeared to be due to the *masking* of these conflicts. That is, there was evidence that chronically over-used defensive strategies were activated by the need to maintain attachment to and proximity with others. This was supported by the psychotherapeutic, assimilation, and pain analogue analyses. In the therapeutic formulation, evidence was given that both clients demonstrated a reliance on a lack of variation in their expressed personality, even to family or intimate others, which reflected a one-sided acceptance of certain traits or qualities. In the assimilation analysis, dominant voices such as *ACE* and *Stoic One* were shown to offer defensive functions.

That defenses might be rigidly used was also supported by certain findings from the psychometric analyses. Both Megan and Lore demonstrated moderate to high defensiveness on the Weinberger Index. Megan reported low levels of 'trait' anxiety (which, along with being highly defensive, qualified her as using a repressive style of coping with her symptomatic anxiety). By contrast, Lore indicated an awareness of relatively high levels of anxiety, and she was also partially aware of her conflicts regarding dependency and establishing herself as a separate but interdependent adult. In light of the preceding discussion on the nature of conflicts revealed, it is also interesting to compare these findings with those of Luborsky, Crits-Critoph, and Alexander (1990) in which the most common conflictual theme revealed in narratives by defensive individuals (as measured by

the Weinberger Index) involved dependency issues, and that neither these nor anger during interpersonal conflict were recognized easily.

In addition, Megan's reporting of other symptoms of distress on the CORE, BDI, and SUIP were unusually low compared to pre-existing data from nonpatient samples offered in conjunction with each scale. It was as if she was indicating a relative absence of stressful moments or experiences in her life, which of course contradicted her presentation in therapy. These results could be further interpreted as another indication of her desire to present herself in a good light, as someone who was capable (the durable *Selfess Server*) and did not complain (the *Stoic One*). That self-report of health may underestimate level of distress as judged by clinicians has been supported by a series of studies performed by Sedler, Mayman and Manis (1993), who demonstrated that mental health scales may be better discrimators of health rather than distress, and that the use of psychological defenses may occlude getting a fair picture of the psychological vulnerability of certain individuals.

It is also worthy of note that the pattern of assimilation for both Megan's and Lore's emergent voices was quite uneven, with periods where their dominant – and defensive – voices returned to re-assert dominance once their emergent voices began developing. There were also profound momentary experiences of loss that accompanied the lessening of their dominant voice's hold on their personality, which took time to understand and accept. With this loss, came other realizations and a backlog of feelings, sometimes sadness and often anger, needing processing and acceptance, with the occasional view that life was indeed easier when these ideas and emotions had been masked away. These characteristics could be seen as *resistance,* or the difficulty had by an established and dominant part of the personality to relinquish control; and the synonymy between the client's experience of self (or *ego*) and this dominant part. Only after a number of occasions in which an emergent part or voice can be heard, could these clients accept these experiences as truly their own. McDougall (1989) and other psychoanalysts (e.g. Read, 1999) have indicated that attempting to interpret these defenses in a challenging way can elicit strong resistance, indicating the entrenchment of the defensive structures involved, and the fear of disintegration that may be kept at bay as long as they are in place.

The degree to which this pattern of assimilation may be characteristic of highly defensive individuals is not known, but awaits further research. Barkham, Stiles and Shapiro (1993) in measuring change characteristics such as client-rated problem intensity, instability of intensity ratings, and the rate of change showed that clients whose presenting problems included symptoms and mood-related items, offered the greatest degree of instability (i.e. the fluctuations in problem intensity over time), which was likely to have impact on the work performed in therapy on these problems. This might contribute to some of the unevenness in assimilation of certain kinds of voices as well, for certain kinds of clients at least.

These findings are consonant with others in which poorer health status and difficulty in acknowledging personal conflicts have been found in repressive or defensive individuals (Esterling et al., 1990; Bonnano & Singer, 1990; Davis & Schwartz, 1987). The measurement of defensiveness in these studies have relied on more than the inhibition of emotional expression; rather they rely on measures in which the client is asked to report on a consideration of their behaviour in terms related to moral integrity (e.g. the Marlowe-Crowne Scale) or from personal interviews and characteristics of interaction with the interviewer. In both cases, the use of avoidant defensive strategies was observed as stylistic patterns of recurrent response. This was consistent with Megan and Lore's dominant voices and their concerns, as well as their resistance to fluctuation.

For Megan and Lore, this fixed reliance on defensive position left them with chronic and mysterious symptoms, which created significant distress. Once again, the results of their psychometric measures echoed this presentation, by indicating that although they were not satisfied with their life quality and experiences, their medical symptoms provided the only explanation they had in attempting to understand and report this problem.

7. 3. 3 *Research Question 3* What relationships can be found between these conflicts and the presence of pain and other symptoms?

Two findings were noteworthy here. One was clients' initial inability to discover mediating factors in relation to symptom episodes, even after concentrated efforts to do so. The other, demonstrated by the pain analogue analysis was that an increase in clients' ability to identify the presence of conflicts and work with them in

different situations was correlated with a decrease in pain intensity. The apparent paradox is easier to understand when the relative unconsciousness of these conflicts is remembered, and that an increase in assimilation refers to an increase in conflict awareness and experiencing, in which the client is eventually able to accept ambivalence and create a bridge between opposing objects or voices. This would explain why earlier reports indicated a lack of correlation between stressful events and symptom onset in cases of IBS (Levy et al., 1997; Suls et al., 1994). Megan was not aware of the relationships between her symptoms and conflicts (Lore had some awareness, some of the time), and both clients expressed at least some confusion over the lack of connection between life stresses and pain episodes. Clients cannot be expected to report a relationship of which they are unaware.

Other studies involving long-term psychoanalysis have also showed that an increase in awareness of conflicts and some working through was concurrent with the disappearance of symptoms in clients (Taylor, 1993; McDougall, 1989), or a change to a new balance in physiological functioning (Moran & Fonagy, 1987), and one of Freud's earliest cases involved a rapid disappearance in hysterical symptoms when the source of the physical distress could be named (Freud, 1905:1933).

In each case, one voice set (i.e. conflict) was associated more often with pain comments (i.e. *Feeling One-Stoic One* for Megan; *Instinctive Feminine – ACE* for Lore). Both of these voice sets were related to emotional experiences and anxiety were handled; in particular the over- modulation of darker emotions and their expression. At the base of this constricted affect, a fear of intolerable loss or disintegration could be hypothesized, indicating the presence of earlier emotional experiences which could not be contained well enough at the time.

Further, these relationships revealed patterns as these abilities developed.
The most severe pain episodes for both Megan and Lore occurred most consistently when conflicts became activated in response to interpersonal situations, although they remained unaware of this internal stimulation. This was consistent with APES Level 0 ratings, but occasional episodes still occurred through Level 2. Particularly for Megan, who resisted *giving in* to her pain and *opening up* to a state of inner distress, pain episodes could eventually render her into complete dysfunction and require hospitalization. When verbal assimilation descriptions depicting her process

began to move through Level 0 towards Level 1, Megan began to shift her ability to think about and respond to her pain episodes slightly, after which more movement of her previously repressed feelings and needs could emerge more often (even though these emergences could only elicit a re-establishment of authority by her dominant voices). Her pain episodes began to shift in frequency and intensity around this time. Lore had fewer severe pain episodes, but these signaled a recurrence of conflict that could be seen only after her response to current events had been processed and understood from this framework at late Level 0 or 1.

Further examination of her APES ratings and ratings of pain intensity indicated that another cluster of pain episodes occurred for both clients as they moved through level 2, although these usually involved new sites or qualities of discomfort, briefer and usually less severe. It appeared that as their once-problematic voices grew stronger, providing more conflict with an opposing dominant voice, new symptoms were likely to develop, producing somatic as well as psychological signs of anxiety and stress. Thus, Lore's angry spots or feelings of unease, and Megan's chest pains or ongoing problems with tooth inflammations occurred as their talk about how they cared for themselves and their own needs began to increasingly conflict with how they usually cared for others. A similar process occurred when Lore's gut feelings were allowed to voice themselves without being stifled by an overbearing attempt to remain cheerful and pleasant at all cost, or Megan's sadistic anger or bitterness could be owned without internal recrimination by her internalized sense of idealized inner strength.

There are several related points that can be drawn here. The very qualities that identified *Stoic One* for Megan, or *ACE* for Lore defended against the emergence of this awareness of the link between inner conflict and somatic pain. The function of these defenses was to ward off (or at least minimize) experiences feared to be painful or self-destroying. Yet the result appeared to be pain of a different sort that was barely tolerable at times. Becoming able to tolerate the anxiety involved in understanding their conflicts brought a cessation of pain for both clients for a time. When conflicts reappeared in new domains (i.e. life situations) *without awareness*, pain would re-appear and leave the client confused, until the relevant conflict could be identified. During this stage of therapy, which covered the majority of the time allotted, this was the central task and focus for the therapist. Varvin and Stiles

(1999) have described a similar process by which defenses against emergent experiences were gradually shifted by helping clients symbolize experiences in a way that reduces the threat and anxiety experienced.

New, less severe symptoms that tended to involve other areas of the body also occurred as clients approached an APES Level 3 awareness of their conflicts in which their opposing voices could offer equal weight. Although this was a stage in which these clients experienced a strong internal struggle, this tension was not somaticised (i.e. it was experienced as psychological discomfort, but its source was understood and owned). Importantly, their experience of anxiety decreased significantly, in their own views. This finding is in accordance with the affective correlates associated with successive levels of the assimilation model (i.e. a decrease in anxiety predicted at late Levels 2 and Level 3). Together, these findings offer a slightly more precise hypothesis about the relationship between anxiety, somatic distress, and conflict. *Active* conflict, that is, engagement with internal conflicts shifted client functioning from a previous pattern of repressive coping and thus appeared to obviate the need for conflict expression through somatisation.

7. 3. 4 *Research Question 4* What evidence is there to support a role for emotional processing in the maintenance of conflicts or their resolution?

As described above, analysis of conflicts in the case of both clients indicated basic problems with emotional processing. Neither client could be described as alexithymic, and both manifested emotional expressiveness with some variation of affect. However, both clients had at least some difficulty identifying feeling states involving certain emotions, and processing them fully in a way that accepted their validity in relating to the environment and to themselves. For each, a conflict was defined in these terms. Further, some progress was made in identifying and tolerating deeper and more difficult feelings, and at the follow –up stage, both clients indicated better quality of life and reduction of pain, which they felt derived from a greater understanding of their own feelings. Lore's *IF* achieved more acceptance – and expression –than did Megan's *Feeling One*, as indicated by the assimilation analysis, however.

That facilitating awareness and tolerance of emotional experience decreases pain intensity has been discussed in other studies described earlier (e.g. Monsen & Monsen, 2002). An increase in affect recognition, and finding safe and non – destructive channels for the expression of particularly deep experiences of rage or grief have been part of client's own accounts in which they have moved *into* their symptoms and feeling experiences related to them. Rothenberg's (2001b) ulcerative colitis was interpreted as symbolic of a deep rage *eating her up.* It needed alternative expression that was connected to the rest of her self community (i.e. where it could be understood and accepted, rather than split off in a dissociated expression), in order for her gastrointestinal disease to finally abate. Her intensive self-analysis provided a framework for understanding; but her series of paintings and the very acts of creating them out of feelings that arose from her own abdomen permitted the necessary transformation in her own views.

The discussion of conflict structure and dynamics above has already offered support for these ideas, and hinted at their role in the genesis of somatic disorder, but a few related points are worth emphasizing here. Megan especially had adopted a pattern of barricading herself against feeling. It became clear in the analysis of *Feeling One,* that Megan was afraid of grief or rage, and feeling overwhelmed. This fear was related to developmental trauma and a fear of further loss, which brought on panic and a sense of potential disintegration she began to share with her therapist. Lore could express her rage and sadistic criticism, but initially only in somewhat dissociated states, or by viewing these behaviours in others. Until she was able to re-experience hurt feelings and begin to entertain her concern over her fear of self-inadequacy within a safe relationship, associated experiences of rage and aggression were blocked off and could not be owned. For both clients, therapeutic tasks involved helping each give further expression to rudimentary or vague feelings of distress and creating a better and more appreciative understanding for them. This included the use of focusing techniques (Gendlin, 1996), and providing a framework for developing associations to feeling states. The presence of strong feeling, such as Megan's irritation with her daughter became an occasion for considering that strong feelings involved more than immediate circumstances, and using these feelings to find links with similar experiences in other events and contexts. A third intervention frequently employed was the simple acknowledgment of the vulnerability and need for acceptance that underlay

Megan's or Lore's experiences of fear or psychological distress, and its normalization.

The relationships between affect, defense, and conflict has not been consensually fashioned into an overall working model, although recent system-based approaches described earlier (e.g. Schwartz, 1989) have attempted to provide a structural framework for these processes. Within theories of psychotherapy and psychosomatic disorder, a controversy over the primacy of conflict or affect still remains. This has been particularly salient within psychoanalytic theory (Gill, 1994). Others' findings that FGID patients may tend to 'somaticise' feeling experiences (i.e. interpret them as symptoms) has focused on the relatively undeveloped emotional processing skills that may create internal anxiety and be interpreted as physical pain (Slepoy, 1999; Chun et al., 1999). Newer approaches attempting to link neuropsychology with neuroenterology such as the dysregulation model of Mayer, Naliboff & Chang (2001) draw on the great overlap between neural circuitry underlying emotions, actions, and digestion. In this model, the pathways involved in emotional processing are directly linked to gastrointestinal dysfunctions, offering support for an affective focus in working with GI patients.

The results of these studies cannot provide an ultimate test of the primacy or centrality of either structure or process, as a focus on identifying conflict dynamics had been chosen. However, the dynamics involved in conflict maintenance involved the blocking of emotional processing in each case. Certain case studies, in which multiple aspects of client functioning have been involved in the case formulation and description of change in somatic disorder, have implicated both the need for developing better affect recognition and expression, and an understanding for conflicts involving the relationship between self and object, and self and other (e.g. Taylor, 1993). The view was shared by Gill (1982) and Krystal (1988) that separating affective from other psychological aspects of experience may not be ultimately useful. However a relevant question still remaining is whether focusing therapeutic goals on developing affective competencies is enough, without providing a framework for understanding the nature of the inner and interpersonal conflicts they are connected to.

For both clients in this study, part of the therapeutic work involved understanding the specific anxieties that were involved in this expression, and finding ways to tap and express these feelings in a safe way. This work tended to evoke other strong experiences involving guilt or shame as well as fear, and being able to contain each client through these experiences was felt to be essential to the therapy. That guilt or shame are feelings that arise in chronic illness have been pointed out elsewhere (Finerman & Bennett, 1995). Here, it appeared that these emotions were rooted in other life experiences as well. For example, Megan's sense of shame figured in the past and present as a primary motivating experience, and so early attempts to enhance her individuality, as exemplified in her *ME* voice, brought about a need for self-punishment, or a reversal of hostility back toward her *self.* Lore's fear of not being seen as socially acceptable were found to derive from earlier experiences in which she had felt undesirable in her appearance and her ability, and had been socially humiliated by bullies at school, or denigrating criticism from her own family. In this regard, Tomkins (1963) and Magai (1996) have described how parental socialisation is a factor in how negative emotions are regulated. Where parents establish fairly rigid boundaries around behavioural expression, children will tend to inhibit negative affect and avoiding shame might become a primary motivation.

The psychometric measures were less useful in delineating the role of affect regulation for these clients in relation to their disorders, although it may be the choice of measures used that was responsible, particularly for the measurement of interpersonal problems. The Self-Understanding of Interpersonal Problems Scale (Connolly et al., 1999) may be a relatively difficult measure for clients, and it does assume a certain amount of psychological knowledge about oneself and one's reactions to others. Similarly, measures of psychological and functional distress like the CORE or Beck measures can only be useful if the response tendencies of the client enable a fair appraisal of inner experiences. As already discussed, in a repressive or highly defensive individual, this may be a problematic assumption.

7. 2. 5 *Research Question 5* How does the assimilation model help explain conflicts and their changes during therapy in clients with chronic abdominal pain?

It should be remembered that the assimilation analysis occurred *after* the therapy was complete, so this commentary on process was retrospective, rather than active in formulating the therapy itself. It did shed light on the therapeutic processes that were occurring; nonetheless, both within the therapist-client interaction and within the client's own internal processing. While the relationship between voices (from an assimilation perspective) and objects (from a psychodynamic approach to structure) was initially linked in terms of conceptual similarity, together both models as they were applied to these cases continued to offer an extended understanding of the dynamic processes in these clients and their change. In particular, the assimilation model proved useful in establishing a framework for understanding the relationship between structures related to client conflicts, and working with them.

7. 2. 5. 1 Defining conflicts and accessible intrapsychic structures

Voice formulation lent to the definition of conflict, and the processes by which conflicts became identified and began to be worked through. Looking for opposing attitudes, or moments when different states of mind appeared to be operating, and casting them into a voice formulation helped to locate conflicts more precisely, and find evidence which enabled their appearance and dynamics to be tracked over time and across events (Honos-Webb, Surko & Stiles, 1998). Consonant with a psychodynamic approach was the model's ability to focus past a client's surface anxiety, and consider it an indication of positive movement when it heralded the surfacing of a conflict into conscious awareness (Honos-Webb et al., 1998; Stiles et al., 1990).

Ultimately, the therapeutic movement in each of these cases as described by the assimilation model did fit the data: each client came farther towards building a more cohesive inner self community, and at the same time, a more flexible, or democratic one (Stiles et al., 1991). For both clients, their dominant voices analysed here appeared to be related by providing a multi-faceted defensive function and social persona. As each client's work proceeded, connections between

her emergent voices became apparent (i.e. *ME* and *Feeling One*, *IF* and *IndA*). In other words, at some point, inner work that facilitated *ME* often affected Megan's ability to hear her feeling voice. Knobloch et al. (2001) describes this phenomenon as *theme convergence*.

This process occurred though the client's ability to engage in conflict work. In particular, Levels 0 and 1 offered descriptions of a relatively unconscious voice-related wish or impulse that is attempting to enter consciousness, and Levels 2 and 3 and 4 describe the conflict created when it become partially successful in doing so. During Levels 1 and 2, the historic and current reasons why dominant voices such as *Stoic One* or *ACE* became favoured as self-traits (and also became used as defenses against other personality traits) began to surface.

The verbal assimilation descriptions helped to outline several processes that reflected smaller movements than the APES ratings alone could indicate. Although these statements could only offer tentative impressions of the processes revealed in the text, they were linked to an agreed rating (i.e. to the relative level of voice or conflict identification, or experiencing and learning) as well as each rater's interpretation of the voice dynamics occurring in each segment of work. Together these descriptions offered stronger evidence of smaller processes inherent in client narrative-based reflection or interaction. With further research these might become part of the larger scheme of stage-related changes associated with APES levels.

Within the assimilation analyses, dominant voices opposing or blocking the emergence of a less developed (or repressed) problematic voice were viewed as representations of defensive structures, which also permitted a social persona maintaining attachments and regulating relationships. Examining moments in therapy in which dominant and emergent voices were present or implied helped to make these defenses more visible. Lore, for example, was aware of her intention to remain bright and cheerful, but as this attitude became more brittle at moments and she realised darker moments of anger and depression, she could better recognise her tendency to pull herself back to the safer *ACE*, which did not always help and neglected the problems it was causing within. Often, and without intervention from the therapist except for the holding of a safe and accepting environment and a

genuine interest in collaborating over the problem of their illness, these clients began to reduce their reliance on these defenses, and develop an objective awareness of it as they began to become more aware of experiences and emotions, and aspects of themselves that had been repressed or stunted in development. In each case, problematic conflicts had become entrenched in a dynamic pattern that represented a partial, albeit symptomatic solution. The ways in which the dominant voice acts as a defensive structure has not been specifically described in the assimilation literature, although the way in which defenses more generally may obstruct the genuine assimilation of emergent voices or experiences has been described (Honos-Webb et al., 2000; Honos-Webb, Lani & Stiles, 1999; Varvin & Stiles, 1999).

A particular value of the assimilation rating process was to highlight the value of engaging in inner conflict, and what happened when clients did so. As Level 3 processes came under focus, clients had the opportunity to become more conscious of the reasons they had previously avoided this engagement as well as work with the fears and feelings that became identified. What may have been earlier identified only as externalised projections (e.g. Lore's *Bully* and fear of being unrecognised and rejected, Megan's fear of incompetence and ostracism) became experienced from within. Establishing a safe *internal* environment for facing a conflict involved similar processes for both Megan and Lore. They included becoming acquainted with these as yet unconscious (or relatively unconscious) emergent voices, withdrawing projections (i.e. reducing the need to focus on others as a means of identifying and relating to the client's own attributes), and exploring historical antecedents creating the present partial solution. Reviewing the historical foundations by which a dominant voice has become prominent in shaping the *self* has been more usually associated with Level 4 –type reflections (e.g. Lani et al., 2002 *stepping back to take another look, using old reactions in a current relationship* markers; Stiles et al., 1991 discussion of case of *John*). Here, reflections on how Megan's dominant *Server* or Lore's dominant *Child* developed and their roles in regulating relationships began at late Level 2. This appeared to be a preliminary movement into a reflective stance, in relation to a voice pair prior to their full emergence (or recognition in the case of the dominant voice). Thus, these clients' understanding of their own voices was still somewhat vague and unformulated, and yet attempting to locate them within historic interpersonal

incidents may have been part of the process of clarifying them in experience. Of course the existence of this preliminary process at an early level of assimilation may have been influenced by the psychodynamic orientation of the therapy (i.e. the therapist offered the practice of looking for links between different kinds of experiences, and so promoted reflection and symbolic interpretation). What needs to be underlined here, however, is that both raters (including one who was not psychodynamic in approach) described the components of this process and its relationship to relatively early stage of assimilation.

Another process that was represented in voice assimilation patterns was reflecting on the value – and limitations of – identifying and valuing only certain attitudes representative of the dominant community. This processes have been noted elsewhere. In the case of Jan, analysed by Honos-Webb et al. (1999), a significant process was when she could look at the limitations of her *Superwoman* voice, even though she could also appreciate it as protective at the same time.

Not all of these smaller processes were part of the original APES model guiding the ratings, nor were they part of other theoretical formulations describing the change process used in the case analyses here. As some occurred across APES levels, they would not be candidates as markers, but they might be more generic processes that occur at some relative points within the overall APES continuum. Those common to both Megan and Lore are labelled and associated levels of assimilation status are summarised across the four voice pairs in Table 7.1. They have been discussed in relation to each case in the findings given earlier.

The importance of any of these processes, described in assimilation language or as psychodynamic concepts is that they offer specification of change processes, and consequently potential areas for intervention, even if the latter merely involves offering encouragement and understanding. For example, the feelings of loss that may accompany a client's reflection of a previous way of being (represented by a historically dominant voice) may be interpreted as resistance towards change from a familiar way of being. Similarly, the client's apperception that her own attitude now appears to her to be inflexible, or less reasonable, can correspond to the early

development of ambivalence. Later the construction of a meaning bridge or new perspective will permit a more agreeable appreciation of the feelings and understanding of different perspectives from a place that can connect the two.

Range of APES ratings	Process steps described in various VAD ratings
0– 1	**Dominant voice offers rationalisation for importance of its self-protective function** **Emergent voice projected onto other and responded to critically or punitively**
1 - 2	**Gradual emergence of emergent voice: first occurring in one, brief domain, then multiple domains in which voice can speak more clearly and longer** **Dominant voice 'snaps back' to re-assert position following emergence of new voice**
2	**Sense of *getting acquainted* with emergent voice, as a new relationship with *self*-part**
Late 2	**Reflect historically on dominant voice from perspective of emergent voice, and dominant voice expression softens (*i.e. loses its rigidity; voicing is softer or less absolute*)**
Late 2-3	**Limitations of dominant voices realised** **Dominant voice qualities perceived in other and viewed more objectively** **Increased vulnerability occurring with further emergent voice expression, and subsequent oscillating back and forth between emergent and dominant voices** **Express loss of familiar, and sadness; a letting-go process**
3	**Reflection on past event and linking with current one as approach to understanding, but tentative and not true insight** **New levels or qualities of experiencing are described; feelings released that may also bring anxiety, but tolerated better**
3→ 2	**Reverting back to conflict and previous and familiar dominance, when new areas of vulnerability arise, and are associated with previously repressed fears or feelings**
Mid 3	**Defiant expression of emergent voice (I'm entitled to feel / be this way) after conflict recognised** **Plans made for a future solution (can envisage changes desired) prior to attempting solutions**

Table 7. 1 Smaller process of change determined by voice analyses and APES ratings

7. 2. 5. 2 Modification of dominant voices during assimilation of emergent ones, and changing qualities of voice dynamics

Suggested in these case studies is that as new ways of perceiving and behaving emerge, older, more defense-orientated ones do not simply fade away. They remain, but may change in form or expression. The concept of a *softening* of the dominant voice occurred in relation to thinking about Megan's *Stoic One.* Her qualities of endurance and choosing to *soldier on* remained, but lost was the harsh criticism of this voice in relation to Megan's – or others' feeling statements. These may represent graded processes or steps in the change of defensive patterns to more flexible strategies, and has important implications for understanding the nature of projection and its role in helping a client identify and re-consider their grasp of certain components of the *Self.*

Similarly, examining client process in terms of the assimilation model helped to define changes in self-object relationships by articulating the ways in which voices spoke, or talked about each other. For example, Lore's emergent *IndA* voice was often implied, early on, as she spoke from *Child.* Thus she had some vague awareness of it, but was more comfortable talking about this part of herself and her capacity for relationship from a distance. Soon *IndA* emerged more strongly, and could speak for herself, even though *Child* would quickly come back and re-centre her thinking, or state of mind. As *IndA* emerged more often and for longer periods of time, especially in the domain of her work decisions and relationships, she could speak about *Child* and reflect on her as an object, rather than immediately experiencing self, although Lore recognised *Child* as herself at all times. The recognition of an inner conflict between these two was growing, and becoming *stuck* in a more conscious and active Level 3- type struggle became possible, along with the fruits of understanding the fears and issues that had kept the status quo of Lore's *IndA-Child* dynamic earlier. This self-objectification appeared to be an important part of Lore's ability to engage with this conflict without needing to defend herself against it.

7. 2. 5. 3 Use of interpersonal narratives for formulating and working with internal conflicts

Another area for integrating dynamic and assimilation theory involved clients' use of external scenarios within their narratives. In these cases, both clients tended to

focus on and be drawn to examples of their unconscious and problematic voice qualities in others, without awareness of this link. Listening again to these dialogues from a perspective offered by voice formulation enabled the raters to hypothesize that clients were establishing a point of view from which to regard the qualities inherent in their own inner conflicts. Dynamically, this point of view afforded some distance, and therefore some safety from the anxiety and guilt of ownership. Rather than only viewing these processes as defensive, and naming them as *projections*, it appeared that these were intermediate processes in which these attributes could be apprehended, along with their impacts on others, including the client herself. This view has implications for therapy, if interpersonal scenarios can be seen as a way that the client may make discoveries about themselves. Stiles, Honos-Webb & Lani (1999) have also hypothesized that client narratives may indirectly express a problematic experience in this way at Levels 0 and 1. Stiles (1997) has further discussed how projective identification (as a form of counter-transference experienced by the therapist) may act as a means by which clients express problematic and unsymbolized experiences *through* the therapist's experiencing. The use of projective and internalisation processes and their role in conflict work need further description and study within actual case scenarios.

7. 2. 5. 4 *Working through* as an emotional process

An examination of the assimilation patterns for emergent voices showed that both Megan and Lore demonstrated apparent regressions within their overall increase in assimilation over time, although this pattern was more pronounced for Megan. The saw-tooth patterns characteristic of their ratings over time indicated periods of clear or consistent assimilation of inner experiencing (as indicated in the verbal assimilation descriptions) which were followed by sudden drops or reversals in ratings for one or more segments of their therapy. These shifts could not be explained by differences in the domain in which the conflict appeared, alone. For Megan's *ME-Server* voices, these reversals occurred when she had achieved consistent Level 2 ratings, which then alternated with Level 1 or 0, for a period. These reversals occurred again when she was working at Level 3, and began alternating at times with Level 2 ratings. For her *Feeling One-Stoic One* voice pair, these alternations occurred at Level 1 with 0, then again at later substages of Level 2 or 3 dropping down to lower levels. For Lore, *Instinctive Feminine*

alternations involving Level 1 and 2 ratings occurred on several consecutive segments of therapy with only occasional drops to lower ratings once she had achieved Level 3. A similar pattern was achieved for *Child,* although there was a greater overall level of variability for the segments rated.

Chronologically- ordered therapy passages have not followed a linear APES sequence in other published cases. For example, one of the problems described for the case of *Vicky* (Knobloch et al., 2001) demonstrated an uneven pattern of assimilation, which began at Level 1 and ended at termination at Level 3. It was difficult for the authors to interpret this result clearly, especially as the other problem tracked showed less fluctuation. In the case of *Jan* (Honos-Webb et al., 1999), both voices tracked over her therapy revealed regressive, zigzagging movements in APES ratings on occasion. The authors stated that there might be a number of reasons for this, including an admixture of problematic themes occurring at any one moment. Another possible reason might be the need this client had to process painful emotion, which needed to occur on more than one occasions, or the therapist's directing such a repetition. Finally Gray, Biran and Stiles (2002) noted that an increase in distress may occur prior to the release of anxiety consistent with functioning at Level 3 when an individual conflict was tracked. If different conflicts reach awareness at different moments, clients' increased distress may come and go at different points during a therapy, rather than a more linear pattern of 'getting' or 'feeling' better. This would be especially true for a therapy which allowed them to work within a whole life focus, or one in which present and past events are invited into the therapeutic arena.

In the studies here, a closer look at the contents associated with these patterns revealed that these events brought about feelings of confusion and vulnerability to threat, from which these clients needed to retreat, at least for a while. This movement was usually not challenged by the therapist. In the case of Megan's more strongly repressive style characterized by her *Selfless Server* and *Stoic One,* it was hypothesized that movement would require a more gradual and layered kind of emotional *working through*, or the re-working or re-construction of this learning within different situations and issues that were both current and historic.

Further investigation may clarify whether different patterns of movement may be an indirect function of different kinds of conflicts, client styles of working, or the therapeutic orientation used. For example, therapy in which the interventions (and content) remained focused on the same problem or conflict area over time may reveal a smoother pattern of change. In addition, both clients were able to assimilate their emergent voices up to Level 3, yet the ratings showed that their gains were not translated into all domains at once. In this way, these regressions or *decalages* in psychological organisation (i.e. similar to ones described by Piaget, 1936: 1952) may reflect spirals in the development of acceptable and more equal dynamics between inner objects or voices. Within assimilation research, the concept of *working through* has been focused on the behavioural application of conflict work to different externalised scenarios at a relatively advanced level of assimilation (Shapiro et al., 1992), other layers of this process may involve the re-working of dynamics at an inner level. An *emotional working through* may involve more subtle integrations of new experiences with yet others, or integrating affective learning with other layers of cognitive understanding at earlier levels as well as later ones.

7. 3 Methodological and Theoretical Issues

Certain caveats need to be addressed in the consideration of these findings.
One problem in measuring processes related to change has been the difficulty in operationalising conflicts, or finding way to describe their movement as therapy or life events proceed, as others have pointed out (e.g. Moran & Fonagy, 1987). This is related to the more general difficulty in researching the practitioner's implicit knowing-in-practice, and how it molds and in turn is changed by the therapeutic interaction (Schon, 1987). This practical or *tacit* knowledge tends to remain unverbalised, and so cannot be tested or refined by mutual or consensual observation or investigation. Therefore it becomes difficult to form hypotheses or seek empirical evidence for their generality to or utility for other cases, but all the more important to begin by trying new forms of measurement and seeking their correlation with other forms of evidence. Here, assimilation theory and measurement was used as one means of finding evidence for movement basically conceptualized within a psychodynamic framework. This process required ongoing comparisons between these two theoretical approaches in order that the

variables measured from one approach continued to have reference in the other. An additional attempt was made to review theory and research from several disciplines in order to try to understand the ways in which psyche and soma have been shown to influence each other, in order to consider their possible application to clients seeking to bridge similar areas of functioning. There are other perspectives that could have been used and may have created other pictures of these case dynamics and their change. The aim of this work was exploratory rather than to predict or confirm specific hypotheses about the relationship between symptoms and psychological events. Thus, it is more appropriate to suggest certain relationships from these findings and encourage further investigations with clients with somatic disorders for future clarification and support rather than to declare their general applicability to other cases of functional abdominal disorders.

The very fact that the investigations here involved only two cases sets real limits on their generalisability in any event. However, there were attempts to triangulate the case formulations and findings associated with processes of change, by means of overlapping methods of data collection and analysis, and the use of interpretations offered by three different cp-analysts, including the therapist at different moments during or following each therapy. The material presented from each case pertained to the research questions posed at the start. Finally, alternative explanations or interpretations were actively sought. Yin's (1992) four commitments for a thorough case study (i.e. bringing expert knowledge to bear on the phenomenon under study, collecting all the relevant data pertaining to it, examining rival interpretations, and pondering the degree to which the findings have implication elsewhere) were constant reminders during the entire process, including the writing stage that took approximately two years. The aim of this process was however to achieve areas of *consensus* in explaining the nature of conflicts and their relationship to symptoms, and the roles of client awareness and emotion to these processes, rather than to test the efficacy of one approach over another (Stake, 1994).

Both the psychotherapeutic and assimilation analyses (and consequently the pain analogue analysis) utilized a conflict-based approach in which the client's relationships to others reflected imbalances between internalised aspects of themselves. The pain analogue analyses involved attempting to rate pain

experiences according to the client's ideas regarding pain intensity or anxiety; however these ratings were applied to their pain talk by the therapist in conjunction with the client, retrospectively during the next session. It would be important in future analyses to have the client rate or qualify pain experience concurrently, and continue to find ways in which conflict status could be assessed in conjunction with symptom onset.

Another methodological issue brought up in this research concerned the picture of change created by patterns in APES ratings. To some degree, these were dependent on the particular segments chosen for rating. It was expressly *not* a goal to try to locate examples from the therapeutic dialogue that represented significant moments of change, but rather any example of dialogue in which either or both voices in a particular conflictual relationship were present. Certainly it was easier to rate those segments in which the voices *as understood by the raters* could be more clearly identified. Therefore, something of the pattern of change described relied on the understanding of the voices and implicit beliefs about how they were likely to change once modified or assimilated. Although an attempt was made to make this description explicit as much as possible, by delineating voices *after* therapy was concluded, both raters came to realise they had somewhat different concepts involving the voices they were rating. This became apparent when the verbal assimilation descriptions were discussed in the consensus procedure. These differences were not due to a lack of clarity in the voice formulation, but more personal differences in the experiential and implicit knowledge framework used by each rater. Rather than simply view this problem as procedural error, these situations became occasions for further discussion of the raters' implicit voice and conflict theories (e.g. beliefs about *Server*-type voices, including reasons for dutiful behaviour and selfless devotion and what a meaning bridge between *Server* and *ME* might look like). They both realised subtle differences in these theories were most likely operative in guiding the rating of passages.

As an example of the process by which conflict assimilation was measured, it points out the need to qualify the terms by which therapy passages have been selected, and the potential bias created by the therapist or researcher to be influenced by assumptions regarding the voices under consideration and how they are likely to change. Passage selection may result in different patterns even when the overall

assimilation (e.g. a comparison of assimilation status at baseline and outcome) remains the same.

In these studies, there was a temptation to view pain as the expression of an emergent voice. If in the case of Megan, her repressed *ME* voice (or the *self* as a central psychological structure combining *ME* and *Feeling One*) was viewed as the inner source expressing pain, then a need existed for further explanatory devices to describe how *ME's* expressions changed (i.e. how they became symbolised or formulated into actual voices speaking words rather than pain), in order for this transformation to be explained. It may be the case, for example, that fundamental or pervasive conflicts involving self-other boundaries are more likely to be expressed as symptoms, but additional theoretical structures need to be offered to explain why somatic expression occurs in some cases but not others.

Similarly, even when voices are well formulated and raters comfortable with their identification in passages, the therapy tape or transcript remains an imperfect record of process, especially without the therapist's understanding of the prosodic and interpersonal contexts in which client utterances are made. Honos-Webb et al. (2000) have indicated additional problems in rating therapy passages for insight or the resolution of difficult experiences into meaningful and positive emotions in this regard. The surface appearance of a client's narrative (e.g. a reading of the content for semantic meaning alone) may give the appearance of these more advanced processes, when for example the client may be borrowing useful psychological ideas (e.g. *sugarcoating*) to defend against a real experiencing of her own dilemmas, rather than revealing real insights about them.

7. 4 Implications for Future Research and Therapy

7. 4. 1 Symptom measurement

These studies have offered support for the relevance and usefulness of an ongoing and multimodal approach to process measurement to assist the identification of conflicts and therapeutic movement in psychosomatic clients. Symptom records were gathered as part of the narratives in these studies, but in retrospect it was felt that a more defined and participative record could offer value as a device within therapy. Analyses of cases where behavioural records such as pain ratings or

conflict measurement are kept in conjunction with the client offer good ways of measuring progress; and they also engage clients in discovering associated factors and changes within their own experiencing. These findings also encourage the need to identify and measure pain or other symptoms in terms of its individual qualities and nuances, within the client's own pain lexicon of experience, in order to understand how it might be signaling different processes with different meanings during a time of change.

7. 4. 2 Overall framework for individual conflicts and change processes

In this study, the relationship between dominant objects or voices and conflicts within the same client was only briefly addressed, and for the assimilation analysis the relative relation of their dominant-problematic status with emergent voices was key to making ratings. Yet the relationship of two dominant voices – or problematic voices – to each other should be addressed further in theory and research, in order to provide a coherent picture of client dynamics and change. Thus *Server* and *Stoic One* could be seen as facets of the internal object described as compliant, silent, and hard-working, and served similar functional roles in regulating the reluctance with which Megan jeopardized her attachments and confronted her own insecurities about her worth and acceptability to others. Further analyses of how these voices appeared and changed in relation to each other, *and* in relation to narrative-related events could provide another bridge with psychodynamic theory and a comprehensive approach to psychological dynamics.

Using a voice formulation early in the therapy might define more specific therapeutic goals or tasks, which may be helpful in time-limited work. A method for detecting voice dynamics during assessment has been offered by Stiles et al. (1997). In particular, voice formulation offers a way to work with resistant defenses by giving them a voice in relation to other, more repressed voices within the person. An early goal of the therapy might involve helping clients locate and work with less assimilated voices, even if their identity was vague . In particular, if in the case of psychosomatic clients like the ones described here, their assimilation of problematic voices is at stage 0 or 1, attention to early intrusions within an articulated assimilation framework may help clients to become collaborative explorer of her own psyche.

7. 4. 3 Establishing a good alliance

One implication of these findings is the potential benefit from therapy for clients who may first appear to be less psychologically minded (or are resistant to considering psychological factors in the genesis of their illness). Therapeutic approaches used may need to be different, and more collaborative. Establishing the safety of the therapeutic encounter needs emphasis, and to be established early on. In these studies, client's perspectives on the alliance, or their views on the importance of therapeutic relationship was not measured. However, the importance of collaborative work within a psychodynamic framework was implied. There are many approaches to establishing a good alliance, not all of which require a great amount of time, but may benefit from innovative structures within the therapeutic encounter. For example, Guthrie (2003) described using an initial three or four-hour session within an eight-session (12 hour) therapy with IBS clients, in which establishing a working relationship is the primary goal. In addition, this interpersonally-based programme included a written formulation of the client's inter- and intrapersonal dynamics presented near the end of therapy, for clients to keep for future development and review. As discussed above, working with the client's defenses and assisting their ability to reflect on them from a more objectified viewpoint (and one which also enables them to use their relationship with the therapist) has been indicated as another important first task. It is useful to consider that clients may be learning to formulate about certain internal experiences for the first time, and that doing so represents a major change in their own internal regulation. Containment for this process (i.e. helping to establish its safety and the therapist's sensitive ability to assist appropriately) is essential.

Focusing on process in an attempt to articulate it lent further perspectives about change, including the relationship of process to outcome. In these studies, outcomes here did not appear to be static states, but snapshots of current functioning that could be compared to earlier measures within a larger picture generated through multiple analytic devices. For these cases at least, outcomes were best viewed in terms of the whole case formulation, *and* the more specific tasks of the immediate therapy, rather than a priori and universal notions of improvement (Stiles, Shapiro

& Harper, 1994). The psychometric outcomes for both clients showed limited improvement, and yet their psychotherapeutic and assimilation analyses revealed significant changes. The relationships between outcomes viewed from different perspectives need further exploration and theory-building as well as empirical investigation, however. In particular, the processes outlined here as indicative of client movement may be somewhat specific to clients who are working on issues pertaining to chronic illnesses, or developing a relationship to their bodies through problematic somatic symptoms.

7. 5 Emerging Themes for Further Inquiry

7. 5. 1 Multiplicity of meanings in symptoms

These findings offer repetitive themes, which have implications for a somewhat different way to think about pain and symptoms and their *multiplicity of meanings* (e.g. pain as a result of defense against conflict awareness; re-appearance of pain as a signal related to conflict divergence, pain as representative of link to body and more body-based levels of experience). For both of the case studies reported here, chronic gastrointestinal pain was complex, and embedded into a matrix of associations and qualities. At a psychological level, evidence was provided that it offered an expression of psychic pain existing at primitive levels of the psyche, which had been warded off, or *disconnected* from other ongoing perceptions of bodily function or *self-* experience. The thoughts, feelings, and images evoked from these clients in relation to their pain experience were not the same as their consciously- held beliefs and attitudes about health and illness and symptom formation or maintenance. In addressing a recent conference of psychiatrists on re-visioning the concept of somatisation, Tait (2003) described the very strong sense of *invalidism* carried by a client suffering with a chronic somatic complaint. The client's very experience of their own bodies and understanding of how they function as an integrated entity of body and mind become *invalidated*; when no one can diagnose or describe why they suffer from continued pain this failure becomes an ongoing echo. Yet it is not only somaticising clients who separate psychological from physical or medical. If more than simply a cultural affectation, it represents a deeper archetypal split between what can be formulated as acceptable experience, on the one hand, and what appears too frightening or chaotic to formulate on the other, engaging in conflict work becomes a heroic task.

7. 5. 2 Symptoms assisting self-regulation

For both Megan and Lore, their episodes of pain could be seen as a *somatic protection.* In Megan's case, it could be argued from her response to historic and current events that pain (as an expression of the rigid use of a defensive voice in response to the stirrings of an emergent *Self*-voice) helped her avoid primitive rage and a fear of disintegration. Once emerged into conscious experience, these voices could lead to humiliation or shame, or worse. At a primitive level, they were feared to be life threatening (to herself, and to others). Such a somatic warning device would be more immediate than a linguistically-mediated one, and could be envisaged as a more reliable prevention. For Lore, pain could have provided some separation of self from other. Her fears of merging when in emotional interaction with others (whose needs she automatically felt asked to serve in some way) were repeatedly problematic: on the one hand she wanted to maintain relatedness and avoid abandonment; on the other, maintain a sense of self kept from feeling engulfed by those she wanted to please. Pain and illness kept others close, but separate. In addition, both women found it difficult to contain criticism and feelings of failure, and their somatic distress may have provided a masochistic response to a punitive or aggressive dynamic, however unaware they were early on of its presence within.

For both women as well, pain appeared to serve to define bodily limits in a very basic, nonverbal way. Lore's occasional *self*-attacks (e.g. pulling her hair, scratching herself) usually occurred after a heated argument with her mother, as if she was attacking her mother's body, in addition to her own. She could register her frustration during such an event, although it reveals a more fundamental need for separation not yet achieved.

If chronic somatisation can be viewed as a partially adequate method of regulating the anxiety accompanying these conflicts internally, while helping to regulate interpersonal ones externally, it makes sense that strong and resistant forces would be in place to maintain this system. When Megan and Lore became more aware of these defenses in terms of their alliance with certain self-views or ways of behaving, it was still difficult for them to consider an alternative way to be.

A slightly different view might be that the physicality of symptom expression and its embeddedness within a medical context was not simply one avenue for warding off an acknowledgment of conflict. Rather, it became an unconscious but very real avenue for expressing it. The tendency for both clients to feel guilt and personal responsibility when considering that their illness had psychological meaning indicated the deep connection between a moral and physical integrity experienced by these clients. It also pointed strongly to the importance of respecting symptoms at the level of their own expression, rather than using them as a signpost and attempting to persuade the client (however subtly) to move their work to a psychological place. Somaticising kept their conflicts close to the body, from where it originated in the realm of instinct, body-based feeling, and an orienting the work to the level of the body and its ongoing, fluctuating responses could be helpful in gaining contact with this source.

7. 5. 3 Developing a meaningful bridge between psyche and soma

A central task of therapy was helping each client understand the nature of her illness and extending her model of psyche-soma relationship. This was not a simple process, and working with conflicts and identifying their relevance to symptom episodes needed time and repeated exposure. This represented another spiralling process involving therapist-client interaction in relation to ongoing life events. Clients needed a quantity of repeated experiences in which a hypothesis regarding a link between their inner responses to life events and the onset of pain could be demonstrated over time. This work was by no means finished for either Megan or Lore by the time they left therapy. In these cases, a period of symptom cessation followed by a sudden and severe episode could be interpreted as *signalling* the re-introduction of a conflict *and* an old tendency to inhibit awareness of it, and unconsciously inhibit particular feelings or impulses from guiding behaviour. When such a recurrence of symptoms followed some work with conflict identification and movement in the client's acceptance of these impulses, the idea of pain or other symptoms acting as a signal was more likely to be heard, and understood.

For these clients, an additional fact was the connection between their ongoing pain to previous disease. Their fear that symptoms might potentially signal ongoing physiological disturbances meant that simply 'psychologising' the meaning of their pain experiences was not sufficient. It also led to the need to work further to develop both a deeper appreciation of their illness experience and the role of the body in each client's acceptance of *self.*

For Megan, the areas of her body affected included her stomach and gut, sites of historical trauma as well as digestion of input from the environment. For Lore, her gut was also the locus for evaluating her own instinctive needs and reactions to others, and often, an area where she experienced the arrows of attack by others. In both cases, a real physical insult (for Megan, a past duct disorder; for Lore, gastrointestinal infection) was paired with important and negative life experiences, which had not been processed adequately and were left as anxiety-constellating conflicts. Schafer (1976) has discussed how different sites of the body correspond symbolically to different emotional experiences. Associations to digestion and excrement include *explosive*, *furtive*, and *poisonous* actions – and generally destructive emotions.

The potential for the symptoms to have positive value became more acceptable as clients recognised and engaged in conflict work. This also reflects the importance given here to collaborating on a new model of psyche-soma relationships, as an essential task in this work and a desirable outcome.

These ideas were helpful in attempting to understand some of the counter-transferential responses that arose. For example, there were times with each client, I felt unusually excluded, on the other side of what felt like deadlocked representations of Megan's or Lore's reality of their lives (Slade, 1994). In response to their stories and their approach to pain, I sometimes felt inept and unacknowledged. Although this was not an altogether unusual worry for me, there seemed to be an unusual enormity to the task of working with clients whose physical symptoms were experienced in such an encompassing and distressing way. Knowing that a psychological interpretation – even in the form of using metaphors – might be intrusive, or overbearing, my anxiety would rise. This concern did at times lead me to respond (albeit unconsciously at the time) by resisting my own

response to acknowledge repeated pattern occurring within the clients' narrative, without realizing at first I was colluding with the client's fear of grappling with her emotional experiences. Over time, I felt swamped, overwhelmed and confused, and finally could begin to understand that these might also be the very experiences that kept each client locked into ongoing and dominant ways of thinking and feeling.

Others have offered that much psychotherapeutic work consists of helping clients formulate experience for the first time, rather than reaching beyond defensive processes that conceal fully formed but unconscious contents (Stern, 1997). This was hypothesized to be an important part of the therapy with both cases, but especially Megan. The need for a model that facilitated a linking between chronic bodily experience and emotional experiences, and addressed the issue of personal responsibility over illness was sorely needed, and not easily taken on. The use of therapy as an intervention here is different from a more educative approach. In these studies, model-building was individualised and represented a collaboration with clients' own terms and ideas, and it was a theme that wove in and out of the length of therapy.

The richness of systems-based approaches being offered by psychophysiologists depict complex and sensitive interactions between gut and brain and the possibility that alterations at any level in the system may subtly affect far-reaching sites (Kellow et al., 1999; Mayer, Chang & Lembo, 1998). These and other models provide a good basis for personal theory-building, between health care professional and patient. It is not the labels for neural pathways and processes that offer explanation; more helpful is the concept of a system and how it regulates its own internal world and its relationship to an external one. Similarly, self-regulation theories may offer another avenue in which both client and therapist can look at the ways in which others in the client's environment serve to reassure, or offer the experience of *self* as special or having personal limitations (e.g. Hinckley, 2000).

In each of these two cases, as therapist and client came together, different perspectives intermingled about the nature of client distress. In particular, the client brought a perspective shaped by medical dialogues, diagnosis and treatment, and a cultural history in which psyche and soma existed on either side of a long divide.

Their own approaches to their bodies, and some aspects of their own inner lives needed healing as well. Medical approaches had been tried in consecutive contacts, as an expert system in which to locate an understanding and hopefully a recovery. As it failed to provide adequate resources for these processes, each patient was left with confusion, disappointment and fear. The case studies here offer some encouragement that therapeutic work may be helpful in addressing these needs, and offer a basis for further investigation into the processes by which both psychological and somatic health may be regained.

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APPENDICES

Appendix A

Psychodynamic concepts

The concepts of *defense, conflict, impulses* or *objects* are fundamental to the notions that inner impulses, behaviours, needs and parts of the *self* may in fact conflict with one another, and certain psychological processes can develop to divide conscious awareness, to avoid these conflicts and keep the individual aware of only more acceptable impulses or parts of the personality. These concepts was central to Freudian ideas about what constituted the unconscious, including aspects that attempted emergence into consciousness in the form of symptoms, unconscious acts, or repetitive forms of behavioural acting out.

An early position taken in the development of psychoanalysis was that instinctual drives, or single impulses arose from the unconscious and sought expression in behaviour (Freud, 1905:1953; 1926: 1959). Freud and Breuer's early work with hysteria patients offered clinical examples (e.g. Freud, 1905:1953). Defenses were unconscious efforts to keep these experiences unconscious and deter their expression in behaviour. The unconscious represented a psychic structure, or location where unformulated or unacceptable experiences could exist without needing to be processed by the conscious mind. If certain emotions or instincts (e.g. aggressive, sexual energies) could be denied admission to consciousness, they would not provoke guilt or shame, and the individual was hypothesized to feel protected against engaging in behaviours that might risk social - and personal - approbation.

Impulses and discharge theory

In the Freudian model, psychic energy (i.e. affective energy) deriving from activated impulses could become blocked or reversed, and find re-location in bodily tension. Affective energy was thought to accumulate in this way, but eventually seek outlets for discharge (Freud, 1926:1959). The relation between emotional arousal and bodily events was assumed; thus specific emotional states were linked to more general states of physiological upset or arousal (seeking an eventual return to a more quiescent state for homeostasis). These concepts provided the earliest ground for hypotheses regarding the connections between psyche and soma.

The primitive energies were believed to represent instinctual responses to events, including bodily appetites, sexualities, rage and aggression appeared to exist in contrast to less troublesome intellectual functions. Their connections to chaotic, and possibly shameful bodily functions such as digestion, menstruation furthered the personal prejudice and the practice of hiding the expression of these impulses as much as possible from social discourse. A main theme in Kleinian psychotherapy later involved a re-focusing on these very same primitive impulses, and achieving awareness of experiences such as envy and aggression. Doing so was proposed to help the person recognise their operation within personal experience, rather than continually repressing them from any level of acceptance which results in dysfunction and pathology (Segal, 1985).

The conflict-related tension that occurred between impulses and other experiences seeking a discharge and admission to consciousness offered an explanation for

repetition compulsion (i.e. why disguised or symbolic expressions of the unconscious conflicts were not adequate to discharge their energy). That is, adequate expression appeared to require direct, cathartic action, or some form of acceptance by the ego. Otherwise, symptoms (disguised expressions) would form until the individual was able to engage with the impulse or experience more directly.

Gill (1963) re-visioned the importance of catharsis after this concept became less fashionable. He believed a re-experiencing was necessary in order for these events to be fully processed and lose their *magnet-like* quality, attracting energy and situations that provided repetitions of earlier events. An intellectual grasp or explanation of events or links between past and present was usually not enough to deliver the repressed material well enough for processing by the conscious mind. Gill (1984) went on to specify that re-experiencing must occur within a significant relationship (e.g. the therapeutic relationship). In addition, therapeutic re-experiencing of previously repressed impulses or feelings, longings or expectations needed to be experienced in the here and now of a containing relationship, and communicated by the client, who needed to be able to, above all, understand these events without the need for her own defensiveness. Obviously, one optimal place for such re-experiencing was with a therapist. Much of Gill's contribution to understanding therapeutic release from repressed emotional material can be derived from his work on decoding transferences and helping therapists focus on the most immediately available relationship, the client-therapist relationship.

Symptoms, symbols and acting *-out*

A fundamental assumption was that impulses seeking expression could route themselves into somatic symptoms, *and* were more likely to do so if their bid for more conscious experiencing and behaviour was refused (Freud, 1926; 1959). Thus, one implication of this model was that impulses and other psychological events required expression in order to fit more comfortably into the personality (i.e. they became less problematic). Paradoxically, in this way their expression could become a step towards acceptance, *even though* it was still unowned (i.e. it was ego-alien) *if* the individual was content to *bear* the symptom or discover the meaning of its expression as a symbol. These ideas fit in conjunction with techniques of psychoanalysis, helping a patient focus and recognise his resistances against viewing these less acceptable aspects of himself (Freud, 1914:1950).

Although impulses and drives were part of Freud's topographical theory, it was re-developed by the British object relations school (e.g. Klein, 1946:1986). Object development and functioning replaced the emphasis on the dynamics between conscious - unconscious structures within the psyche. Object representations or schemas were could be refashioned with the further assimilation of experience, as part of the natural development of the child's ability to internalise the world and feedback about the self. More importantly, they acted as somewhat autonomous parts within the self, and therefore could conflict with others. Conflicts between these structures were natural; a balanced dynamic between them reflected the individual's capacity to assimilate very different experiences of self and other in ongoing relations with the environment, but normally some objects could evoke more acceptable responses from the individual's ego than others.

The development of good objects within the self involved more whole representations of others, rather than either all-good, or all-bad aspects of an individual's relationship with them. This also required the ability to form a coherent but flexible awareness of *self* along with others (Kohut, 1971). Experiences of 'good' and 'bad' others (depending on their responsiveness to the individual's needs) at different moments resulted in different representations of that person initially (e.g. a giving *or* a withholding mother). Only at a later stage of infancy could these experiences be joined together into one whole concept of the *mother*, that was ultimately more dependable than the all-good one. Object relations theory was less concerned with describing how others became schematised within the psyche, however, than how these internalisations functioned in the individual's expectations and responses to others; that is, how they formed the active knowledge used by the person. The development of objects acted as a means by which particular feelings, behaviours, qualities or attributes could be *known*, as the individual's own experiences or as they were projected into (perceived in and attributed to) others. Their ultimate referent however remained the individual's own psyche or self, which needed to interact with and know others, even project its own qualities and affects onto others, in order to know itself (Kahn, 1994). The object relations approach also shifted psychodynamic theorising to an interpersonal-based model, by offering the view that *self* and *objects* were psychological structures developed from interactions with the environment, and served the individual's ability to develop an adequate capacity to make satisfactory relationships as well as hold a satisfactory view of self.

Object relations theory was rooted in developmental theory. In order to develop adequate self and object structures, infants needed a 'good enough' fulfilment of physical, cognitive and emotional needs for nourishment, comfort and encouragement in the face of anxiety (Winnicott, 1974). This was the basis by which basic knowledge of the self could occur. Others were needed to show us we are special and worthy of care. Growth to independence and mature interdependencies with others, along with the capacity to tolerate frustration, further required the development of fairly stable yet flexible self-structures that could provide nurturing and esteem-building responses when they were not available from the immediate environment. These capacities became the inner resources providing experiences of pleasure and confidence, and enabled the individual to continue to expand his skills and knowledge. Thus, building good objects was not simply the means by which the individual could like herself and feel competent; it was the only means by which she could truly *know* herself. Having negative or poor self-concept in this perspective became synonymous with inadequate *self*-development.

The lack of adequate holding and caring exchanges with the environment was similarly synonymous with experiences of rejection and more generally, a belief in the inadequacy of the environment to contain the individual's experiences and sustain her through her distress. These experiences would be internalised in interpersonal terms (i.e. as *bad* objects) and would deny adequate opportunity for *self*-development. A variety of object representations might result, that would perpetuate a continuing lack of *need*-fulfilment. These could include images of forbidden gratification of pleasures, or punitive and persecutory responses to need states (Segal, 1974).

Examples of objects and object development are contained throughout the clinical literature. They offer potentially endless complexities here regarding the kinds of structures result from the internalisation of experiences. An example could be provided by the following case example involving a young man. When as an adult, he encounters experiences of loss or rejection, he remains unaware of the impulses of rage these events stimulate within him. Instead, he experiences sharp feelings of incompetence or self-loathing. Within an object relations perspective, one explanation is that his keen sense of self-dislike has become activated by a critical object within. This object also tends to become activated in response to the presence of others who represent achievement or authority. Developmentally it might be hypothesized in this case that sadistic aggression stemming from a primitive experiences of frustration and fear have been split off and projected onto others; in this case a caretaker who in reality was sometimes angry when frustrated and yelled at her infant as a consequence. The experience of the angry caretaker can be re-internalised as a critical and punitive object within. This leaves the individual to become victim to both inner impulses of rage and aggressive feelings experienced masochistically, and an equally hurtful super-ego-like object which punishes from within in response to emergences of these more primitive feelings (Caper, 1998).

Object relations approaches offer hypotheses regarding how impoverished self and object representations could become the basis for problematic transferences, and symptoms. Transferences would occur when objects were projected into others in interpersonal relationships, creating the potential to stimulate similar conflicts within the self. In this way, repressed experiences might act like an inner magnet, in drawing the individual towards similar experiences - and people - in order to have the opportunity to re-experience conflict that has been avoided (Kahn, 1994).

Object relations theory and self psychology have been criticised by ignoring the role of the body in the genesis of and manifestation of conflict (Gill, 1994). Self-regulation theory (e.g. Kohut, 1977;1971) went further to describe how individuals also needed to establish ways to limit the amount of tension and pain experienced in managing these functions, and this will be explored further in a later section. The ability to create good emotional experiences became a function of the ability to receive gratification from both an environment of others and inner fantasies or relationships between self and objects; the two are believed to exist as correlated developments

Use of defensive strategies

Anna Freud's theory offered the emphasis that defenses represented the unconscious part of ego formation (i.e. that although they were part of the functions normally associated with conscious awareness of *self*, they themselves were unconscious). Also central to her theory was that when an impulse and affect was warded off from consciousness, then something else must take its place, such as a paradoxical attitude, or symptom. Anna Freud's approach to understanding defenses was described in relation to a basic objective of therapy: to create an acceptable passage into consciousness for impulses and their associated affects by interpreting and lessening the client's need for them, at least within the sanctuary of the therapeutic relationship. Later neo-Freudians agreed that keeping impulses and other psychic contexts warded off required a certain amount of energy that became *bound* to the continual defense process, rendering it unavailable for other kinds of psychological functioning.

Aggressive impulses were believed to provide the strongest need for the repressive defenses. Somatic symptoms were also offered as symbolic expressions of affective responses and their conflict with the boundaries established by ego functions. Drawing on early work by Reich and others, A. Freud was interested in establishing a relationship between the habitual use of certain defenses and types of psychopathology such as obsessive-compulsive personality and narcissism, as Sigmund Freud had done with repression and hysteria. These have only been partially supported by further investigations of character-based defensive styles (Horowitz, 1979). Reich's (1949) focus on defensive operations themselves fostered a long-lasting line of research and clinical inquires into their nature and operation His clinical observations included examples of narcissistic, obsessional or hysterical pathology and their associated somatic features derived from case examples, and led to hypotheses regarding particular types of *armouring* accompanying these pathological forms of personality.

Although his theory was met with a critical response, the general idea that a relatively *fixed* use of certain defensive strategies could potentially alter the organ systems of the body (and thus reveal something about the nature of impulses and conflicts that underlay them) has been supported by other clinical examples, in which the impact of therapeutic movement has changed somatic dysfunction (Taylor,1993; McDougall, 1989). Alexander (1950) offered a view of development that described how habits related to the expression of psychic conflicts might be formed, and they may have impact on health. His theory has been described as a drive-based theory, but his ideas refer to conflicts between developmental agendas for agency and relatedness that underlay somatic disease. For example, asthma was one disorder believed to be a symptom symbolising unconscious and unfulfilled dependency needs at odds with more acceptable behaviour and feelings towards those whom the dependency needs may be focused (e.g. often the mother). The asthmatic individual was therefore someone who continually exercised emotional restraint in holding back needs for dependency, protection, and affection out of a fear that they might be pushed away and lose the needed relationship. When such feelings and self-acknowledgments were held back, no emotional release of tension was achieved. Of course, expressing feelings of anger or aggression would even be more prohibited, as they might create the loss of relationship.

Still other psychoanalysts have differentiated other kinds of defenses (Vaillant, 1977; Horowitz et al., 1990). In addition, the use of primary defensive strategies has been a major feature in defining individual types of pathology, such as personality disorders. For example, paranoid-types of personality disorder or psychosis are identifiable by the fixed use of projection and introjection; obsessional neuroses feature reaction formation or ego alternation and isolation.

As Horowitz et al. (1990) have pointed out, any study of defense dynamics requires the presence of three conditions: the existence of a motivational force seeking to bring some content into conscious expression, the capacity to process these motives into some form that will gain access to conscious representation, and the anticipation of the consequences of what will happen once that awareness might be achieved. In clinical example, the proof of this motive is accomplished retrospectively, once the target of defense (i.e. the psychic content) is no longer blocked out of consciousness. This content is usually considered to be painful emotions, self-criticism, and memory (or anticipatory fantasies) of others' hostility, rejection, or withdrawal of regard.

Finagrette (1969) offered another conception of defensive processes, in relation to a more complex network of contents as its target; in addition to defending against impulses, there was a developmental history of socialised experience with these impulses that was part of the defensive operation.

> 'The result of defence is to split off from the more rational system (i.e. the system being defended) a nuclear, dynamic complex. This nuclear entity is a complex of *motive, purpose, feeling, perception*, and *drive towards action*. It is, for example, an angry and competitive impulse to damage one's father as an object of envy, or it may be an erotic and competitive impulse to arrange matters so as to be the adored son. And in such cases there is typically a sense of guilt as an element in the complex, the guilt being of a kind that is appropriate to a relatively infantile appreciation of the impulse and its expression. Also integral to such impulses is a limited but genuine capacity to adapt [its] expression.... to varying reality situations.' (1969,p. 129; italics mine)

This view of a fragment of ego structure split-off from a more integral and rational ego foreshadowed the development of object and object conflicts that were developing at the time. Impulses or drives could develop a different sort of agency and autonomy, attracting attributes outwith the domain of the instinct, the layer of the psyche most close to the body. As complexes, they contained both goals and agency, but because they had not been developed past an infantile stage, they were not tolerable and were linked with deeper experiences of shame or guilt. As their existence remained outside of conscious ego functioning, their form remained rudimentary and static. Since they were experienced as ego-alien, they did not have access to the reflective processes of the more established ego. Thus, they could not develop further. This view had important implications for therapy, as accessing and assimilating such primitive aspects of the personality would require their development, and not just a relaxing of the defensive structures protecting the individual's own accepted sense of self-identity.

Further questions about the validity and utility of the construct of defense have been raised. Finagrette (1969) described a last paper begun by Freud before his death and never published, where he puzzled over the problem of ego function and its split between maintaining defenses at an unconscious level, on the one hand, and registering ongoing experience and relating on the other. Freud did not resolve this issue and the paper was left unfinished. This meant that part of the ego was conscious and active in experiencing, while another part was unconscious. For Finagrette and others, this was a core problem for psychoanalytic theory. Stern (1997) addressed this problem by arguing that in order to determine its lack of suitability for processing in ongoing experience, a content must be first appraised. Mechanisms for 'unconscious appraisal' have not yet been postulated. In response to a fundamental need for unity and integrity, it became important for the psyche to find acceptable ways to reject contents without being seen as doing so (i.e. being recognised as an act of self-deception). Gill (1963) in a similar argument offered the solution that defenses do not usually occur alone. Rather, they exist in a series, with some closer to awareness than others.

Another response to this problem would return to Freud's original notion (1926; 1959) that defensive processes belong to a psychological realm close to the instinctive and therefore physiological aspects of functioning. Examples of classical conditioning have shown that unrecognised and seemingly *irrelevant* aspects of a stimulus situation may become associated with powerful emotional states, without conscious apprehension. The ecological validity of this process can be understood, even if the mechanisms supporting it have not been specified. Alternatively, as in recent approaches to functional theories of emotion described earlier, a second but highly

sensitive information processing system may apprehend information quickly from both the internal and external environment without either conscious awareness or linguistic formulation being involved, or possible. This kind of 'radar' would be useful in helping an individual form response sets even if he did not know the reason. If its message was to avoid contact with the message being received, this might circumvent any other analysis of the internal or external stimulus situation. Like any other processing heuristic, the possibility would exist that these circumventions could create problems, however.

The association of a previously neutral stimulus or stimulus condition could become an instigator of anxiety, activated regardless of how often the individual argued against its relevance. Such a stimulus might be an impulse or memory from oneself. This very *irrationality* is a feature of both the conditioned association of paralysing fear, and a defense against awareness of a further impulse the fear might be associated with. The problem posed above might then change to the query, *what creates the ability to be perceived*, even at a very liminal level, as a potentially intolerable, or indigestible experience?

Theories of self-regulation, and attachments

Other theoretical approaches have focused on how certain regulatory functions occur, and the deficits that occur when development has been inadequate. Both cross-species investigations in attachment and biological regulators of attachment behaviours and developmental concepts from *self* psychology (including psychoanalytic, cognitive theory and experiential therapy) have contributed to *self* models, and they have been applied to psychosomatic case studies. Self psychology, particularly the theory of *self* offered by Kohut (1991, 1977) was primarily concerned with explaining long-standing personality difficulties in general and narcissistic problems in particular (Hingley, 2001). Another self-regulation approach was offered by attachment theory and the offering of its relationship to research in developmental biology (Fonagy, 1999; Bartholomew & Horowitz, 1991).

Disturbance in which there are effects on both psychological and physiological processes involve certain kinds of individuals who have failed to achieve an appropriate level of self-regulation (Taylor, 1993, 1992). Individuals with dysregulated personalities were believed to suffer a developmental arrest, resulting from an inability to develop adequate object relationships at an earlier period. In the adult, an impaired ego capacity for containing and modulating narcissistic rage (i.e. frustration when needs for self-esteem and understanding are not understood in the environment) was believed to result, along with poor ability to differentiate other emotions or establish an adequate external network of resources as well.

Dysregulation underlying any somatic dysfunction that might be one result was not viewed as defense against unacceptable affect. Rather this kind of unstable self-organisation would be its basis. Problems in regulating affect derived from the more primary and structural problem of the *self*. Kohut (1977, 1971) posited the idea of a *self* that was different from earlier conceptualisations of ego functioning. Like other object relations theories, his self psychology involved the development of self and objects, or structures representing internalised aspects from ego and interpersonal functioning over time. However, Kohut also suggested that others could serve as external regulators of *self* beyond infancy, after the development of

inner objects derived from interpersonal experience began. His theory was also based on the understanding that even well functioning individuals had healthy narcissistic needs for being appreciated and prized for their uniqueness. These needs and their fulfilment were essential for developing a stable, full and flexible self-concept.

What was needed from the care taking figure involved adequate *mirroring*, or letting a young child know he was special and prized, even in his temporary failures, and respected for the competencies achieved. It also involved *containing*, or accepting relatively confusing emotional expressions from the caretaker's own ability to empathise, understand, and remain stable. It later required understanding the growing child needs to *idealise*, or develop an attachment to an idealised figure as a model of qualities or attributes to which it aspired; and even later, work through their *disillusionment* when the idealised idols were found to have flaws. All of these processes were normal developmental ones; without them, the ability to develop appropriate internal representations would be lacking. These developmental processes were necessary for relatedness as well. Future disillusionments would require successful processing of prior ones along with the individual's capacity to hold onto what was idealised or hopeful for future accomplishment or self-development.

Kohut emphasised these processes as an elaboration increasing in complexity. Self-regulation included an experience of stability to one's experience of *self*, one's good feeling and regard for *self*, and the ability of the *self* to soothe when insult did occur, offer a non-threatening viewpoint, and feel empowered to construct solutions to problems when conflicts between *self* and external others occur.

Others have emphasized the importance of early relationship experiences as central to the individual's ability to establish a solid and functional sense of self, and function well in interpersonal relationships. In particular, empathic mirroring and containment of affect have been seen as critical in this respect (Winnicott, 1960; Bion, 1962).

Attachment theory

The impact of attachment style and behaviours on health status has been a focal point in recent research and theory (Bartholomew & Horowitz, 1991; Luborsky, Crits-Cristoph & Alexander, 1990). According to Bowlby, the primary biological function of attachment was to protect the person in the face of perceived threat, not only in childhood but in the remainder of life (Ainsworth & Bowlby, 1991). Attachment behaviours were considered active and goal-orientated in their effort to restore a secure state of mind, reduce anxiety, and offer escape from an environment perceived to be frightening or uncaring. As an interpersonal construct, attachment style involved both behaviours that attempt to attain and result in maintaining proximity to *stronger* or more powerful others, and how disturbances in these behaviours could be characterised. For those whose natural needs for attachment were frustrated in infancy, later on they will simultaneously experience a need and defense against it. This paradox makes sense, as individuals don't want to repeat the frustration or abandonment experienced earlier. The stimulation of the need itself becomes a motive to avoid it.

Attachment theory did not rely on psychological structures defined as ego or self, but patterns of behaviour and response to situations that are guided by a *working internal mo*del of self and world. Such models implied a relatively central or core pattern of organising past and present experience and predicting future ones that would prevail over many situations and thus had pervasive impact over how most events would be construed. Also implied, however were the defensive functions served by these patterns of behaviour, helping the insecurely attached individual from approaching further painful, intolerable experience, and lending to systematic and symptomatic ways of perceiving, thinking and behaving.

Attachment theory offered an alternative to the more traditional concept of transference (Slade, 1999). It offered the universal need for comfort and protection during times of vulnerability (which includes the therapeutic process as well as the problem that brings the client into therapy), and the located the impulse to seek a wise therapist as a basic need separate from individual attachment style. The therapeutic relationship itself could become a context in which dynamics within could be contemplated and shared, in an emotionally available and 'safe' containment. The degree to which clients were willing to face uncomfortable feelings and awareness of self within, depended of course on their experience of the security of the attachment they achieved within the therapy.

Fonagy (1998) has claimed that there are indisputable differences between self-regulation and attachment models on the one hand, and ego psychology on the other, however, especially with regard to the way in which the connections between psychological and biological functioning are handled. Self-regulation theory is posited as seeking *genuine* phenomena at the level of biology in order to describe the primary level of psychological functions being served (e.g. the biological regulators of attachment behaviour), whereas ego psychology uses somatic events as symptoms, or metaphors, without any knowledge of any mechanistic connections involved.

Appendix B

Description of the Assimilation Model

The original assimilation model relied strongly on cognitive concepts utilized within an experiential and *self* psychology. Within these orientations, therapeutic progress was believed to involve assimilation of problematic experiences into the client's existing schemata. Rice and Saperia (1984) described how a client's *problematic experiences* resulted from a lack of assimilation, or adequate processing of an experience into a person's knowledge system or *schemas*. Problematic experiences resulted in tension and symptomatic distress usually not understood at first by the individual. In their early work, assimilation researchers defined a schema as a 'familiar pattern of ideas, a way of thinking [or living].....that might refer to a tightly organised theory, a metaphor, a narrative or script, or a more loosely organised network of association (Stiles et al., 1990; p. 412). In total, a client's schemata were believed to represent a reference frame through which further experience was filtered. This frame was not meant to represent a set of abstract principles but a more active basis for knowledge that was continuously changing with a person's ongoing experience and behaviour. Schema-inconsistent experiences were believed to be warded off, as they could not fit well into the existing knowledge system and their organisation. The goal of assimilating the new experience was to enable its acceptance within modified, or accommodated schema where it could continue to operate more flexibly This required several steps representative of both the assimilation and accommodation processes (Stiles, 1997).

Problematic experiences were reformulated as *voices* within the person (Honos-Webb & Stiles, 1998). Like problematic experiences, voices were constructed from experiences, particularly interpersonal experiences and their internalisation. Rather than represent different aspects of an integrated personality, voices represented at least partially independent and active entities within the self-structure, or personality, that reflected particular sets of experiences or attitudes, or ability to relate in a particular way within certain environments. Different voices were expected to speak within a client's therapy, in relation to the ongoing narrative and within the client-therapist relationship.

> 'Assimilation, in the voices formulation, involves building a meaning bridge that links an unwanted voice – the traces of problematic events or relationships – with an established community of voices that is the self. The intrapersonal process of assimilation is understood as parallel to the interpersonal process in which two people initially oppose each other, begin to communicate with each other, and ultimately reconcile their differences. ' (Stiles & Angus, 2001, pp 114-115)

Problematic voices may not be in emergence, if initially they have been warded away successfully from awareness. There presence can be detected however as the symptom or symptoms that create distress (psychological pain, somatic symptoms) and furthermore leave the person in confusion, that is without understanding of what is going on inside of himself. Eventually as voices emerged, they might be weak and hard to identify or the person may dislike their feeling and actively attempt to deny or brush them away. Eventually, in favourable circumstances, the voice becomes

stronger and identifiable and become more accepted within the person's experience of self, and this process will have impact on other ways in which the person will think, feel and behave in the future. The relationship between dominant voices (i.e. ones previously accepted within the community) and emergent ones was believed to change in predicable ways across the levels or stages presented by the model. Examples of these changes and their pattern across sequences of therapy have been evidenced in assimilation analyses of cases (Honos-Webb et al., 1999).

The concept of multiple self-structures which may reveal imbalances or a lack of flexibility in their operation has been found in other, cognitive and person-centred descriptions of personality and self development (Mearns, 1999; Linville, 1987). These accounts go further in addressing the importance of this complexity, or 'configurations' within the self for healthy personality functioning, beyond the assimilation model's treatment of how parts or voices ultimately may resolve conflicts produced by their very genesis (i.e. a growing and elaborating personality) and the dynamics which result between them. The *self* could constellate different relationships between its parts, and thus produce different configurations in different situations. This arrangement would be more likely to result in a greater resilience against stressful or new environmental encounters (Linville, 1987). Mearns (1999) describes these as similar to set of family relationships, noting how as a system, relationships and active roles taken may shift depending on the circumstances (i.e. the interpersonal encounter), although members themselves retain their character. As in a family system, the presence of different members and configurations taken gives the system more strength and potentially more adaptability in new contexts.

Often a person's different voices can be experienced by others as a change in tonality, and other prosodic features (Osatuke et al., 2002), along with a shift in intention, feeling and attitude. For example, a person whose interested and engaging voice reflected a basically trusting and open personality might also reveal a critical and moody voice, along with the voice of a frightened and vulnerable child. While other aspects of the person's sense of identity would remain constant, their active experiencing and relating to others would generate more specifically from one or another voice within. If one of these voices (such as the open, interested and trusting voice) was dominant, it might be problematic for the individual to identify and understand, that is, permit the emergence of and acceptance for, the critical moody voice. If the latter voice was assimilated at level 2.1 (early level 2) the person would be somewhat diffusely aware of it and its identity but would still have trouble owing it as part of herself, and would not be aware that its conflict with the open trusting voice was the basis for her current distress.

In this hypothetical scenario, the vulnerable, frightened child might be accepted (and thus assimilated) as part of this individual, but viewed only as active during certain kinds of contexts or environmental encounters and otherwise quiescent. These voices, when emergent, would be likely offer different points of view about the saliency of certain events, or respond differently to the same encounter. When present, they might *sound* like the mood states differentiating them, as well as offer thoughts and feelings more consonant with their individual identities. In addition, more than one voice might be active and emergent at the same time, and result in a dialogue within the person, particularly if conflicting views about an event were in evidence (for example, between the open, trusting voice and the vulnerable, frightened voice) and

the person wanted to reflect on this conflict. In order for this to happen, both voices would need to be assimilated.

The sequence of assimilation stages (the Assimilation of Problematic Experiences Scale; APES) represented a changing relationship between one dominant and one problematic, or emergent voice chosen for describing the current problematic experience Both the dominant and problematic voices were believed to change in the process of constructing a meaning bridge, that is, they develop an understanding between each other. The scale marked the changes in their relationship, and the affective consequences this entailed.

The Assimilation of Problematic Experiences Scale
abbreviated descriptions of each stage are derived from Honos-Webb, Surko and Stiles, & Greenberg (1999), and Stiles, Meshot, Anderson and Sloan (1992).

Level O **'Warded off'**	Content related to problematic voice (PV) is not formulated by client; not aware of nature of problem. 'Warded off' refers to evidence of avoided topics or problems (e.g. emotionally disturbing topics lead to client changing subject raised by the therapist). Affect may be minimal, reflecting successful avoidance; vague negative affect (especially anxiety) is associated with levels .1 to .9. Presence of problematic experience (PE) may take form of somatic symptom or behavioural acting out.
Level 1 **'Unwanted thoughts'**	Content related to PV reflects emergence of thoughts associated with discomfort. Client prefers not to think about it; topics are raised by therapist or external circumstances. Negative affect growing stronger; often more salient than the content and involves strong feelings—anxiety, fear, anger, sadness, which may be unfocused and their connection with the content may be unclear. Panicky feelings may appear when PV intrudes into awareness. Levels 1.1 to 1.9 reflect increasingly stronger affect and less successful avoidance.
Level 2 **'Vague awareness emergence'**	During early part of stage, PV is in evidence, and client can engage with (e.g. speak through) more successfully, without dominant voice rushing in to take over as quickly. Negative affect escalates during the early stage, and associated feelings and thoughts occur. After 2.5, client can articulate PV for longer periods, but it is still weaker than dominant voice, and their conflict with each other is becoming clearer. Levels 2.1 – 2.9 reflect increasing clarity of expression of PV in different domains and PE.
Level 3 **'Problem statement clarification'**	Client able to make clear statement of problem, and PV and dominant voices are more equally weighted. Opposition and struggle felt as voices talk to and about each other, but anxiety and more generally, negative affect decreases; client engaged in struggle more actively and without fear. Plans for action described (what it would take to resolve

	conflict). Levels 3.1 – 3.9 reflect active, focused working towards understanding PE and negotiating between voices.
Level 4 **'Understanding insight'**	Content reveals that voices reach new understanding with each other (meaning bridge). Links between current domain of conflict and other examples may occur, or historical understanding of how community got to be that way (potential 'aha' experiences). Affect may still be mixed, but intensity is diminishing; less painful. Levels 4.1- 4.9 reflect progressively greater clarity or generality of understanding, usually associated with increasingly positive affect.
Level 5 **'Application, working through'**	Learning is used on interpersonal problems and decision-making in current functioning. References to specific attempts at problem solving are made; alternatives considered or tried out, with partial but not complete success. Affect is businesslike, optimistic, but may have some disappointment. Levels 5.1 to 5.3 reflect tangible use of self-knowledge in applied circumstances.
Level 6 **'Problem solution'**	Client able to successful solve a problem; feels pride in achievement. Affect is positive, satisfied. Levels 6.1- 6.9 reflect generalisation of solution to other problems and perhaps incorporating into habitual responses. Sense of conflict between voices gone; their differences can still be appreciated.
Level 7 **'Mastery'**	Ideal state in which client automatically generalises solutions. Voices are integrated, serving as resources in new situation. Transitions between voices are smooth. Affect is neutral.

Research studies

In the last decade, the assimilation model has been applied to analyses of therapy case material in several published research studies, and has become a major catalyst in exploring different aspects of the therapy process. It has been applied in both quantitative studies involving the formulation of voices and rating them in excerpts of transcripted records of therapy dialogue (Reid & Glick, 2002; Honos-Webb et al., 1999; Stiles et al., 1992), and qualitative accounts of conflict resolution (Stiles & Angus, 2001; Varvin & Stiles, 1999). The model has been applied to cases involving process-experiential therapy (Honos-Webb et al., 1998), psychoanalytic therapy (Varvin & Stiles, 1999), and cognitive-behavioural therapy (Shapiro et al., 1992).

In a joint project, researchers from the Assimilation Research Group (Miami University, Ohio, USA) and the Sheffield Psychotherapy Projects (University of Leeds, UK) have accumulated findings from a number of related studies supporting the idea that different approaches to psychotherapy appear to focus on different aspects of assimilation. In particular, exploratory approaches (e.g. psychodynamic, experiential, interpersonal) were believed to be more effective with clients whose problematic experiences could be rated at levels 0 – 2, while more prescriptive

approaches (e.g. cognitive and behavioural) suited therapeutic work at levels 3-5 (Stiles et al., 1997a; Stiles et al., 1992; Shapiro et al., 1992; Barkham et al., 1990). Different ratings of progress involving therapists, clients and assimilation researchers demonstrated that smoother transitions occurred when a combination of exploratory and prescriptive interventions were used in the order suggested above.

Attempt to locate and describe 'markers' or client behaviours that reliably occurred at one stage only led to a series of studies utilizing a number of different cases and therapists from a variety of orientation (Lani et al., 2002; Honos-Webb, Stiles & Surko, 1998). Other applications have included using the APES descriptions during initial assessment sessions in order to establish useful directions for therapeutic work (Stiles et al., 1997b). This resulted in dimensions such as the specificity and internality of a client's problematic experiences, and her affective distress / richness of understanding related to it. These dimensions could be rated and an APES level determined for the client's relationship to her problematic experience.

In other examples, this model has been demonstrated to fit the assimilation of traumatic experiences. Trauma has been defined as experiences that are phenomenally different from a client's knowledge of or expectations about the *self* or world or elicit feelings of extreme fear or horror or shock (Janoff-Bulman, 1992; Horowitz, 1986). In the case of extreme trauma, Varvin & Stiles (1999) point out that a comprehensive change of life perspective may be needed, requiring major personality or structural changes. In these cases assimilation may be a lifelong process and not completely obtained within a single therapeutic treatment. APES measurements have also provided a useful ground for comparing case progress and relative types of change (e.g. symptom reduction) as a partial explanation (i.e. lack of problem statements may leave clients in continued state of confusion and anxiety if termination occurs prior to a level 3 rating of problematic experiences (Honos-Webb, Stiles, Greenberg & Goldman, 1998).

The explicit purpose of the model was to guide clinical researchers' understanding of the therapy process in order to help them conceptualise what was happening as clients resolved voice conflicts. Based on empirical findings, the model provided an understanding of what a healthy personality looked like, as a community of voices within a *self.* In addition, it provided a structure in which to research the therapy process further, by offering a basic framework into which further examples of functioning at each stage or APES level could be described and shared among researchers. Although users were cautioned that the model did not prescribe how therapists should work, it did suggest goals or tasks relevant to the client's current level of functioning, as defined by assimilation level of a problematic experience or voice prominent in the client's dialogue (Stiles, 1997). For example, evidence that a client has vague awareness of a newly emerging voice offers the potential for focused therapeutic intervention in order to further articulate and familiarise the client with this previously avoided part of himself, as a first step towards understanding its conflicts with more acceptable voices.

Appendix C Description of transcription notation

In the analysis of therapy segments extracted from transcribed tape recordings of sessions, the following notation was used.

S2-766 APES = 0 Defiantly wants to be identified with dominant voice; denies negative impact of role.
Megan is talking about a frail elderly woman who needs help and special care; without it she is likely to suffer ill consequences and Megan feels there are no others to help care for her. Therapist is only one to articulate the difficulty of her assumed role.
[T] ....but also being the one, the identified person.....the mother and manager for so much, so many people.
[Cl] Yeah [*therapist hast feeling that she blanked out for a sec*]. I don't like to be left out. There is this other lady; we are trying to get help for her too, there is us, and three other wardens. And we are all trying, well, one or two are....we've been trying for a wee while to get someone to look at her.....

This sample of Megan's transcript will be used to denote some of the symbols below.

Identification and rating

S2- refers to the therapy session number (i.e. the second therapy session) **(in bold face)**. Note that the initial interview session is denoted as **SI-**

-766 refers to the tape/ line number on which the segment begins; along with the session number it serves as an identification number for the segment **(in bold face).**

APES = 0 **in bold face** refers to the consensus APES rating, which in this case is level 0 (refer to the APES scale in text or in Appendix X). In the case of a continued disagreed rating between the two raters, these are given separately along with the identity of the raters (E.g. **0 = MR, 1 = MG).**

The consensus verbal assimilation description (VAD) follows this rating, in bold text. (e.g. **Defiantly wants to be identified with dominant voice....**)

Where raters gave different reasons (even when their ratings agreed) these are both listed. This is also the case where raters continued to disagree on the APES level assigned to the segment..

Contextual information needed to aid understanding of each excerpted passage precedes the segments in italics before each individual segment. (E.g. *Megan is talking about a frail elderly...*)

Segment notation

[T] refers to the therapist's dialogue following

[Cl] refers to the client's dialogue following

..... At the beginning or end of dialogue indicates that the portion represented here picks up from previous dialogue

contained in transcript, or that additional dialogue follows end of segment (E.g. ....but also being the one.....)

(*italicised comments in parentheses*) Memoed qualifiers indicating vocal tone or other prosodic elements contributing to meaning of dialogue expressed.
E.g. (*harshly*), (*eyes move upward quickly to therapist's face*).

[*italicised comments in brackets*] Memoed qualifiers contributing to understanding of dialogue (e.g. response of therapist to nonverbal presentation, location or meaning of reference being made).
E.g. [Cl] Yeah [*therapist has feeling that she blanked out for a sec*].

+ + Plus signs used in text for each speaker (client and therapist) indicates overlap or interruption while other is speaking.
E.g. [T] It seems you +
[Cl] + I don't think I want to go to....

...[ ]... Brackets between dots with text surrounding on either side indicate either portion of dialogue has been omitted. This happens when the recording of speech has not been understood, or when a long portion of speech by client or therapist has been purposely omitted to save space, and removing it does not alter the meaning of the text or add something new to topic (e.g. it is repetitive, consists of mms or other fillers, or offers detail which is tangential to the interpretations or ratings made about it). Pauses however are indicated. E.g. (*short pause*)

PATIENT INFORMATION SHEET

Counselling for patients with functional gastrointestinal disorders (FGID)

We invite you to participate in a research project. We believe it to be of potential importance. However, before you decide whether or not you wish to participate, we need to be sure that you understand firstly why we are doing it, and secondly what it would involve if you agreed. We are therefore providing you with the following information. Read it carefully and be sure to ask any questions you have, and, if you want, discuss it with outsiders. We will do our best to explain and to provide any further information you may ask for now or later. You do not have to make an immediate decision.

This research is being performed to develop new services for patients with certain kinds of gastrointestinal disorders called functional gastrointestinal disorders (FGIDs). These disorders can create a good deal of discomfort. Patients may need to consult health care providers more often. Evidence exists that some methods used in by therapists or counsellors can help people with some illness symptoms, and help patients assist their own recovery. This is not to say that we think some patients are faking their illness, or that they are 'maladjusted.' Rather, it is now accepted that some illnesses like FGID are created by both physical *and* emotional factors, which disturb the body's ability to regulate normal functions, such as digestion. In fact, the methods we use in this treatment are most commonly used with healthy people who simply wish to explore how they respond to events, untangle problems they are having currently, or learn new ways to deal with life concerns.

In this study a number of patients with symptoms like yours will have the opportunity to meet individually with a counsellor for a series of sessions (usually around ten sessions over a three-month period). You will see the same counsellor each time and you will meet in a hospital office with privacy. This study is small (about 35 people) so we can offer a fair number of sessions to each person and find out what is most helpful to people suffering FGID. Everyone will have the same contact with one of the counsellors, although no two people are expected to talk about the same things. In each session, which will last around 45 minutes, you can talk to the counsellor about your symptoms or any other problems you have that are bothering you at this time. You will never be asked to talk about anything you do not wish to. Instead, the counsellor will try to help you in whatever way feels appropriate to you. This is called a 'patient-centred' approach to care. The counsellors have been well trained by an accredited university programme, and have much experience in working with different kinds of people, including people coping with uncomfortable physical symptoms. We have funds to pay for your travelling expenses. We will try to arrange session times that suit your schedule and convenience (evenings and weekends will be possible).

Anything you say in your session with the counsellor is confidential and will not be shared with anyone else, including your doctor. Records or notes from your time with the counsellor will be available only to him / her and one other member of the research team (a professor of counselling from another university). These records will be coded with an identification number known

only to the counsellor, and no one else will have access to your file. When the project is completed, your session records with the counsellor will be destroyed.

Your medical treatment will not be affected in any way if you do not choose to participate in this study. You will receive the same medical treatment (e.g. medication, nutritional advice, repeat visits) WHETHER OR NOT YOU PARTICIPATE. Participation in this study is entirely voluntary and you are free to refuse to take part or to withdraw from the study at any time without having to give a reason and without this affecting your future medical care or your relationship with medical staff looking after you.

An introductory session will be set up with one of the counsellors to answer all your questions about the study and the counselling treatment. You do not need to decide immediately if you want to participate. If you decide yes, the counsellor will ask you to keep track of your symptoms by giving you a special symptom diary to take home. You will also be asked to fill out some questionnaires at the beginning of treatment and also at the end of treatment. You will also have the chance to talk about your reactions to the approach used. Remember the main purpose of this study is to find ways to help people dealing with difficult symptoms and improve the quality of their lives.

We do not expect you to experience any discomforts from this treatment. However, if you are dissatisfied or unhappy with this treatment, you may discontinue whenever you wish, and will have the opportunity to talk about this with another staff person if you desire.

We are performing this study to learn more about the kinds of problems faced by people with FGID, the reactions they have to these symptoms, and what kind of help they need learning to manage their symptoms. You will have many chances to talk to the counsellor about what you find helpful in your sessions and what is not so helpful, including the final session.

If you decide to participate, we hope and expect the counselling treatment to benefit you in one or more ways. Different patients have benefited in different ways, but most feel they have gained greater understanding of how they respond to events or how they handle their own emotions, and have been helped to find other ways to respond or cope if they so want to learn some additional ways. We also expect your participation to help us understand what it is like for other people who live with FBD, more generally, and this study's outcome may help us make a case for offering extended services for other people like yourselves. Participants will be informed of the results by autumn, 2003.

Contact name for any questions: [redacted]

CONSENT FORM

A psychological-based treatment for patients with functional gastrointestinal disorders

PLEASE CROSS OUT AS NECESSARY

Have you read the Patient Information Sheet? YES/ NO

Have you had an opportunity to ask questions and discuss this study? YES/ NO

Have you received satisfactory answers to all of your questions? YES/ NO

Have you received enough information about the study? YES/ NO

Who have you spoken to? Dr./Mr./Mrs. .....

Do you understand that participation is entirely voluntary? YES/ NO

Do you understand that you are free to withdraw from the study:

* **at any time?**
* **without having to give a reason for withdrawing?**
* **without this affecting your future medical care? YES/ NO**

Do you agree to take part in this study? YES/ NO

Patient's Signature ..... Date .....

Patient's name in block letters .....

Telephone number where patient can be contacted:

..... (Home) ..... (Work)

Doctor's signature ..... Date .....

Letter to GP

[redacted]

19 May 00

Dear[redacted]

[Patients name e.g. Joan Jones **]**
[D.O.B. and address]

As you know, Ms Jones has recently visited the (endoscopic fast track) outpatient clinic for investigation and has met with her physician regarding the results. We were notified that Ms Jones fits the recruitment criteria for a study being conducted at the Department of Digestive Disease and Clinical Nutrition in association with the Division of Psychology and Counselling at the University of Abertay-Dundee. In this study a sample of patients suffering functional digestive disorders will receive psychological treatment from one of our specially trained counsellors. Patients will be invited to participate in several (average expected of ten) counselling sessions at the hospital, although the exact number will depend on the individual. Our aim is investigate more clearly the kinds of psychological issues and dynamics exemplified by these patients, and study the intervention processes that are most associated with change in perspective or self-understanding. More description about the study is enclosed in the attached page.

We have discussed the study and its requirements to your patient, who has indicated initial interest in participating. We are writing to ask if you know of any reasons why this patient might be unsuitable for the study (e.g., he or she is already engaged in another form of counselling or psychological treatment at your practice or is awaiting referral to mental health services; or has a long-term history of treatment by mental health professionals or psychotropic medication) and if not, to notify you about your patient's future participation. In addition, if you have any questions about the study, please do not hesitate to contact any one of us by telephone or email. Of course, patient material from the treatment sessions will be held in confidence, but patients may choose to speak with you about their work within these treatment sessions. Other medical treatment occurring at this hospital or within your practice will not be changed or compromised in any way, whether or not your patient ultimately participates in this project.

Thank you for your attention in this matter, and do not hesitate to get in touch with us if you have any questions.

Yours sincerely,

Mary Reid
Research Psychologist
Ninewells Hospital and Medical School and University of Abertay-Dundee

Defining a psychological treatment approach and measurements of therapeutic gain for patients with functional abdominal pain and other FGIDs

Functional gastrointestinal disorders (FGIDs) create a good deal of discomfort, and patients often need to consult health care providers frequently. New and interdisciplinary treatments need development. Evidence exists that some methods used in psychotherapy can help people suffering long-term illnesses, and make life adjustments which may have possibly contributed to their symptoms in the first place. This is not to say we believe these patients are maladjusted or simply 'somaticizing' psychological problems. Rather, it is now accepted that some illnesses like FGIDs are created by both physical (i.e, neuroenteric dysregulation) and psychological factors (e.g., how emotional experiences are processed), which disturb the body's normal functions.

A small group of patients diagnosed with functional abdominal pain as a primary symptom and being treated within TUHT will be asked to participate in psychological treatment, which aims to help them become more aware of ways they may be restricting their experiences of living, including their recognition of emotion, or the ways they tend to relate to others. The approach derives from newer psychodynamic and process-orientated or experiential approaches to treatment. It may also help patients deal with apparent obstacles in living created by their symptoms, and so has some similarity to problem-solving or behavioural approaches.

The study's purpose is to be able to define the treatment used more precisely, and describe in more detail the interventions used that both therapist and patient believe lead to improvements in patients' functioning. We will also gather outcome data to see if this treatment appears to have an impact on patients' symptom severity and general well-being, although a real test of treatment effectiveness will be set up in a trial later.

We are currently seeking funding to help support the costs of this service-based research, and have received helpful feedback on a related research proposal from a Scottish Hospitals Endowment Trust.

Patient data will be kept confidential in accordance with the Data Protection Act, 2000, and all records of his or her sessions will be destroyed upon completion of the project. This research study has been approved by the Tayside Committee on Medical Research Ethics (Ref 021/00). Your patient will be given feedback regarding the findings of the study. If you would also like copies of the papers that will be produced for professional medical and psychology journals, please let us know.

Ms. Mary Reid	Professor CR Pennington	Professor John McLeod
School of Social and Health Sciences University of Abertay- Dundee [redacted]	Department of Digestive Disease and Clinical Nutrition Ninewells Hospital and Medical [redacted]	School of Social and Health Sciences University of Abertay-Dundee [redacted]

Appendix F

Psychometric and Pain Measures

Pages 450-454 have been removed due to copyright restrictions. These items consisted of the Beck Anxiety Index, the Beck Depression Index, and the Clinical Outcomes Routine Evaluation.

Illness Perception Questionnaire

1. Core symptoms

Please indicate how frequently you now experience the following symptoms as part of your illness:

Use these ratings **0=never,**
1= occasionally
2= frequently
3= all the time

Symptom	Rating	Symptom	Rating
Pain		Sore Eyes	
Nausea		Headaches	
Breathlessness		Upset Stomach	
Weight Loss		Sleep Difficulties	
Fatigue		Dizziness	
Stiff Joints		Loss of strength	

2. Views on illness

We are interested in your personal views on how you see your illness. Please indicate how much you agree or disagree with the following statements about your illness.

Use these ratings: **SD = Strongly disagree**
D = Disagree
N = Neither agree or disagree,
A = Agree
SA = Strongly agree

C	A germ or virus caused my illness.	**SD**	**D**	**N**	**A**	**SA**
L	My illness will improve in time.	**SD**	**D**	**N**	**A**	**SA**
I	My illness has not had much effect on my life. (R)	**SD**	**D**	**N**	**A**	**SA**
L	There is very little I can do to improve my illness. (R)	**SD**	**D**	**N**	**A**	**SA**
I	My illness has strongly affected the way that others see me.	**SD**	**D**	**N**	**A**	**SA**
C	My illness is hereditary – it runs in my family.	**SD**	**D**	**N**	**A**	**SA**
T	My illness is likely to be permanent rather than temporary	**SD**	**D**	**N**	**A**	**SA**
C	Stress was a major factor in causing my illness	**SD**	**D**	**N**	**A**	**SA**
I	My illness has become easier to live with. (R)	**SD**	**D**	**N**	**A**	**SA**
C	Other people played a large role in causing my illness	**SD**	**D**	**N**	**A**	**SA**

T	My illness will last a short time. ®	**SD**	**D**	**N**	**A**	**SA**
C	My illness is largely due to my own behaviour	**SD**	**D**	**N**	**A**	**SA**
I	My illness has serious economic and financial consequences.	**SD**	**D**	**N**	**A**	**SA**
C	Pollution of the environment caused my illness	**.SD**	**D**	**N**	**A**	**SA**
L	My treatment will be effective in curing my illness.	**SD**	**D**	**N**	**A**	**SA**
C	It was just by chance that I became ill	**SD**	**D**	**N**	**A**	**SA**
C	Diet played a major role in causing my illness.	**SD**	**D**	**N**	**A**	**SA**
T	My illness will last a long time.	**SD**	**D**	**N**	**A**	**SA**
C	My state of mind played a major part in causing my illness.	**SD**	**D**	**N**	**A**	**SA**
L	What I do can determine whether my illness gets better or worse.	**SD**	**D**	**N**	**A**	**SA**
C	My illness was caused by poor medical care in the past.	**SD**	**D**	**N**	**A**	**SA**
I	My illness is a serious condition.	**SD**	**D**	**N**	**A**	**SA**
I	My illness has had a major consequence on my life.	**SD**	**D**	**N**	**A**	**SA**
L	There is a lot which I can do to control my symptoms.	**SD**	**D**	**N**	**A**	**SA**
I	My illness has strongly affected the way I see myself as a person.	**SD**	**D**	**N**	**A**	**SA**
L	Recovery from my illness is largely dependent on chance or fate. ®	**SD**	**D**	**N**	**A**	**SA**

Note: (R) is reversed scored for subscale score total.

The Personal Reaction Inventory

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide if the statement is true or false as it pertains to you personally.

For each statement below, circle T or F:

1. Before voting I thoroughly investigate the qualifications of all of the candidates.	**T**	**F**
2. I never hesitate to go out of my way to help someone in trouble.	**T**	**F**
3. It is sometimes hard for me to go on with my work if I am not encouraged.	**T**	**F**
4. I have never intensely disliked anyone.	**T**	**F**
5 On occasion I have had doubts about my ability to succeed in life.	**T**	**F**
6. I sometimes feel resentful when I don't get my way.	**T**	**F**
7. I am always careful about my manner of dress.	**T**	**F**
8. My table manners at home are as good as when I eat out in a restaurant.	**T**	**F**
9. If I could get into a movie without paying and be sure I was not seen I would probably do it.	**T**	**F**
10. On a few occasions, I have given up doing something because I thought too little of my ability.	**T**	**F**
11. I like to gossip at times.	**T**	**F**
12. There have been times when I felt like rebelling against people in authority even though I knew they were right.	**T**	**F**
13. No matter who I'm talking to, I am always a good listener.	**T**	**F**
14. I can remember 'playing sick' to get out of something.	**T**	**F**
15. There have been occasions when I took advantage of someone.	**T**	**F**
16. I'm always willing to admit it when I make a mistake.	**T**	**F**
17. I always try to practice what I preach.	**T**	**F**
18. I don't find it particularly difficult to get along with loud-mouthed obnoxious people.	**T**	**F**

19. I sometimes try to get even rather than forgive and forget.	**T**	**F**
20. When I don't know something I don't at all mind admitting it.	**T**	**F**
21. I am always courteous, even to people who are disagreeable.	**T**	**F**
22. At times I have really insisted on having things my own way.	**T**	**F**
23. There have been occasions when I felt like smashing things.	**T**	**F**
24. I would never think of letting someone else be punished for my wrong-doings.	**T**	**F**
25. I never resent being asked to return a favour.	**T**	**F**
26. I have never been irked when people expressed ideas very different from my own.	**T**	**F**
27. I never make a long trip without checking the safety of my car.	**T**	**F**
28. There have been times when I was quite jealous of the good fortune of others.	**T**	**F**
29. I have almost never felt the urge to tell someone off.	**T**	**F**
30. I am sometimes irritated by people who ask favours of me.	**T**	**F**
31. I have never felt that I was punished without cause.	**T**	**F**
32. I sometimes think when people have a misfortune they only got what they deserved.	**T**	**F**
33. I have never deliberately said something that hurt someone's feelings.	**T**	**F**

Personal experiences scale

Circle T for true or F for false for each statement below.

1) I am often sick to my stomach.	**T**	**F**
2) I am about as nervous as other people.	**T**	**F**
3) I work under a great deal of strain.	**T**	**F**
4) I blush as often as others.	**T**	**F**
5) I have diarrhoea (loose bowels) once a month or more.	**T**	**F**
6) I worry quite a bit over possible troubles.	**T**	**F**
7) When embarrassed I often break out in a sweat which is very annoying,	**T**	**F**
8) I do not often notice my heart pounding and I am seldom short of breath.	**T**	**F**
9) Often my bowels don't move for several days at a time.	**T**	**F**
10) At times I lose sleep over worry.	**T**	**F**
11) My sleep is restless and disturbed.	**T**	**F**
12) I often dream about things I don't like to tell other people.	**T**	**F**
13) My feelings are hurt easier than most people.	**T**	**F**
14) I often find myself worrying about something.	**T**	**F**
15) I wish I could be as happy as others.	**T**	**F**
16) I feel anxious about something or someone almost all of the time.	**T**	**F**
17) At times I am so restless that I cannot sit in a chair for very long.	**T**	**F**
18) I have often felt that I faced so many difficulties that I would not be able to overcome them.	**T**	**F**
19) At times I have been worried beyond reason about something that did not really matter.	**T**	**F**
20) I do not have as many fears as my friends.	**T**	**F**
21) I am more self-conscious than most people.	**T**	**F**

22) I am the kind of person who takes things hard.	**T**	**F**
23) I am a very nervous person.	**T**	**F**
24) Life is often a strain for me.	**T**	**F**
25) I am not at all confident of myself.	**T**	**F**
26) At times I feel that I am going to crack up.	**T**	**F**
27) I don't like to face a difficulty of make an important decision.	**T**	**F**
28) I am very confident of myself.	**T**	**F**

for office use only

Total items _____

Standard score _____

MC score _____

Classification _____

Exhibit 9.23 The EuroQol Quality of Life Scale

By placing a tick (thus ✓) in at least one box in each group below, please indicate which statements best describe your own health state today.

Mobility

1. I have no problems in walking about ☐
2. I have some problems in walking about ☐
3. I am confined to bed ☐

Self-care

1. I have no problems with self-care ☐
2. I have some problems with self-care ☐
3. I am unable to wash or dress myself ☐

Usual activities

1. I have no problems with performing my main activity (e.g. work, study, housework, family or leisure activities) ☐
2. I have some problems with performing my usual activities ☐
3. I am unable to perform my usual activities ☐

Pain/discomfort

1. I have no pain or discomfort ☐
2. I have moderate pain or discomfort ☐
3. I have extreme pain or discomfort ☐

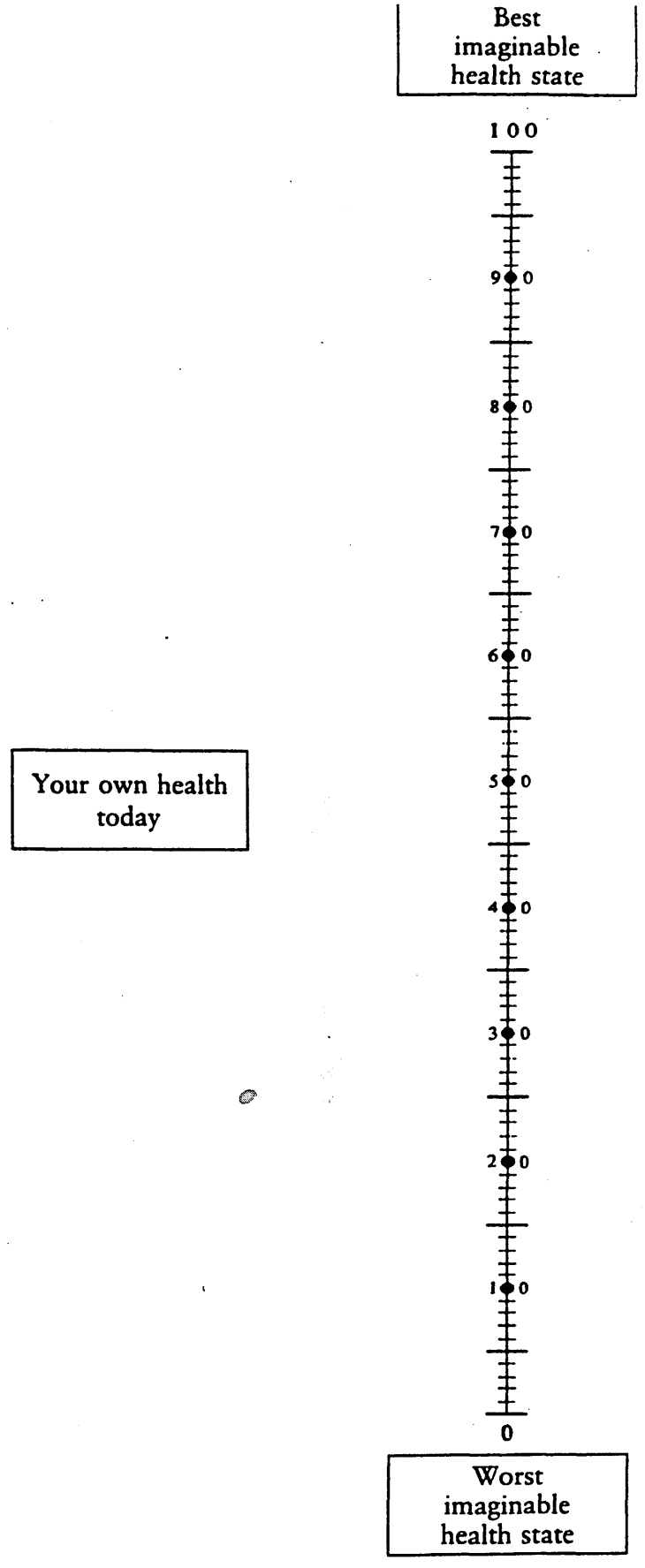
Anxiety/Depression

1. I am not anxious or depressed ☐
2. I am moderately anxious or depressed ☐
3. I am extremely anxious or depressed ☐

Visual analogue scale

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked by 100 and the worst state is marked by 0.

We would like you to indicate on this scale how good or bad is your own health today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is.



Adapted from an original provided by Dr. A Williams. With permission.

Cognitive Scale for FBD **ID/name**_____ **Date** _____**ST**_____

Consider each of the following statements. Indicate your agreement or disagreement with each statement, in terms of how much it applies to YOU or YOUR thinking and feeling over the PAST MONTH, in each case.

Use the following scale for your responses:

I disagree strongly	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**I agree strongly**

Rate your agreement with each statement below, as it pertains to you over the past month:

♠ I worry about not getting to the bathroom in time not being at home when the pain gets bad.....	1	2	3	4	5	6	7
♠ I'm always sick with bowel problems /pain.....	1	2	3	4	5	6	7
My symptoms are too much to handle.....	1	2	3	4	5	6	7
♠ I can't function normally when I am ill with bowel problems / pain.....	1	2	3	4	5	6	7
♠ My bowel symptoms / pains are an agony to me.....	1	2	3	4	5	6	7
It is important that I do my absolute best at everything.....	1	2	3	4	5	6	7
♠ I get frustrated by my bowel symptoms / pain.	1	2	3	4	5	6	7
I worry that the pain will never go away.....	1	2	3	4	5	6	7
♠ I feel very low about my bowel symptoms / pain symptoms.....	1	2	3	4	5	6	7
♠ I am concerned about passing wind / feeling uncomfortable in public.....	1	2	3	4	5	6	7
I worry about not finding a toilet when I need one.....	1	2	3	4	5	6	7
♠ My bowel problems / pain problems interfere with feeling good about myself....	1	2	3	4	5	6	7
♠ I worry about my bowel symptoms / pain on a trip.....	1	2	3	4	5	6	7
I can't concentrate due to the pain.....	1	2	3	4	5	6	7
It is embarrassing to keep going to the toilet.....	1	2	3	4	5	6	7
I get concerned about lasting through events.	1	2	3	4	5	6	7

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Being late for things upsets me.....	1	2	3	4	5	6	7
I hate making a fool of myself.....	1	2	3	4	5	6	7
♠ I feel I cannot take advantage of opportunities due to my bowel problems / pain.	1	2	3	4	5	6	7
My symptoms make me feel out of control.....	1	2	3	4	5	6	7
♠ I worry about my getting bowel symptoms / pain in a restaurant.....	1	2	3	4	5	6	7
When I make frequent visits to the toilet, others think that something is wrong..	1	2	3	4	5	6	7
♠ I worry about losing control of my bowels in public.....	1	2	3	4	5	6	7
I worry about not being able to cope in public.....							
I find myself feeling guilty if I nurture or do things to please myself.....	1	2	3	4	5	6	7
I must get home if I have symptoms.....	1	2	3	4	5	6	7

Personal Symptom Scale **Week beginning _____2000**

Symptom 1 _____Abdominal pain (sharp)_____

a. During this past week, the worst my _____sharp pain_____ever got was……..

0	1	2	3	4	5	6	7
n / a	very slight						extremely severe

b. During this past week, the number of days I had _____was …….

0	1	2	3	4	5	6	7
							days

Symptom 2 _____Windy, bloated feeling _____

a. During the past week, the most bloated I felt was ……..

0	1	2	3	4	5	6	7
n/ a	slightly						extremely

b. During the past week, the number of days I felt _____bloated or windy_____ was ……

0	1	2	3	4	5	6	7
							days

Appendix - The Chronic Pain Grade Questionnaire

For the following questions with a scale of 1-10 please circle one number only

1. How would you rate your pain on a 1-10 scale at the present time, that is right now, where 0 is "no pain" and 10 is "pain as bad as could be"?

No pain — Pain as bad as could be

0 1 2 3 4 5 6 7 8 9 10

2. In the past six months, how intense was your worst pain rated on a 0-10 scale where 0 is "no pain" and 10 is "pain as bad as could be"?

No pain — Pain as bad as could be

0 1 2 3 4 5 6 7 8 9 10

3. In the past six months, on average, how intense was your pain rated on a 1-10 scale, where 0 is "no pain" and 10 is "pain as bad as could be"? (That is, your usual pain at times you were experiencing pain.)

No pain — Pain as bad as could be

0 1 2 3 4 5 6 7 8 9 10

4. About how many days in the last six months have you been kept from your usual activities (work, school or housework) because of this pain?

0-6 days	
7-14 days	
15-30 days	
31 or more days	

5. In the past six months, how much has this pain interfered with your daily activities rated on a 1-10 scale where 0 is "no interference" and 10 is "unable to carry on activities"?

No interference — Unable to carry on activities

0 1 2 3 4 5 6 7 8 9 10

6. In the past six months, how much has this pain changed your ability to take part in recreational, social and family activities where 0 is "no change" and 10 is "extreme change"?

No change — Extreme change

0 1 2 3 4 5 6 7 8 9 10

7. In the past six months, how much has this pain changed your ability to work (including housework) where 0 is "no change" and 10 is "extreme change"?

No change — Extreme change

0 1 2 3 4 5 6 7 8 9 10

Self-Understanding of Interpersonal Patterns

This scale has two parts. Do the first part, then go on to the second part when you have finished the first part.

Part one

Consider each statement below. Indicate whether you think each statement is relevant to your current life (i.e, whether it describes you, or something you feel is true about you). If it is relevant (i.e, it describes you), then circle YES. If it is not relevant (i.e, it does not describe you), circle NO. Go through the entire list of statements before you go on to Part two.

Part two

Now go back through the list of statements. For each statement that you have circled **YES**, complete the 4 point self-understanding scale below.

Self-understanding ratings

1) **I recognize that I feel and act this way with a significant person in my life, but I don't know why.**
2) **I can see that this experience has become a pattern with multiple people in my life, but I don't know why.**
3) **I'm beginning to see a link between these experiences and past relationship experiences, but the connection is not yet clear.**
4) **I can clearly see that I feel and act this way because of past relationship experiences.**

Interpersonal Pattern	NO	YES	Self-understanding rating			
1. I feel the need to 'save' or 'rescue' others when I see them having a tough time, and therefore try to solve their problems for them.	NO	YES	1	2	3	4
2. I feel the need to guide others when I see them about to make a mistake and wind up telling them what to do.	NO	YES	1	2	3	4
3. I feel the need to please others and let them push me to do something I don't want to do.	NO	YES	1	2	3	4

Self-understanding ratings

1) **I recognize that I feel and act this way with a significant person in my life, but I don't know why.**
2) **I can see that this experience has become a pattern with multiple people in my life, but I don't know why.**
3) **I'm beginning to see a link between these experiences and past relationship experiences, but the connection is not yet clear.**
4) **I can clearly see that I feel and act this way because of past relationship experiences.**

4. I need someone to truly understand me, and feel hurt when he/ she cannot relate to my feelings.	**NO**	**YES**	**1**	**2**	**3**	**4**
5. I feel the need to keep someone close, and do whatever is necessary to keep him / her with me, even when they need to leave me.	**NO**	**YES**	**1**	**2**	**3**	**4**
6. I feel the need to change someone, and wind up helping him/her to think more like me even when he/she has beliefs or values different from me.	**NO**	**YES**	**1**	**2**	**3**	**4**
7. I feel the need to be understood by others, and get defensive or angry when others are not able to see things like I see them.	**NO**	**YES**	**1**	**2**	**3**	**4**
8. I feel the need to be close to someone, and have difficulty letting them have the space they need.	**NO**	**YES**	**1**	**2**	**3**	**4**
9. I am very dependent on others for approval, and feel hurt when they reject me.	**NO**	**YES**	**1**	**2**	**3**	**4**
10. I need to be trusted by someone, and feel rejected when they do not trust me.	**NO**	**YES**	**1**	**2**	**3**	**4**
11. I need to trust someone, yet I distance myself from that person when they act in a dishonest way.	**NO**	**YES**	**1**	**2**	**3**	**4**
12. I feel the need to be accepted by someone, and feel bad about myself when he/ she doesn't like me.	**NO**	**YES**	**1**	**2**	**3**	**4**

Self-understanding ratings

1) **I recognize that I feel and act this way with a significant person in my life, but I don't know why.**
2) **I can see that this experience has become a pattern with multiple people in my life, but I don't know why.**
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13. I need someone to take care of me, and I feel abandoned when he / she is not helpful.	**NO**	**YES**	**1**	**2**	**3**	**4**
14. I need someone to be reliable, and I feel disappointed when he / she lets me down.	**NO**	**YES**	**1**	**2**	**3**	**4**
15. I need to feel accepted by others, and I feel bad when they oppose what I want to do.	**NO**	**YES**	**1**	**2**	**3**	**4**
16. I need to feel free of responsibility and I distance myself from someone I care about because they are too dependent on me.	**NO**	**YES**	**1**	**2**	**3**	**4**
17. I need to be respected by someone, and I feel hurt when he / she does not approve of me.	**NO**	**YES**	**1**	**2**	**3**	**4**
18. I want to accept someone else, but I am forced to distance myself when they do not live up to my expectations.	**NO**	**YES**	**1**	**2**	**3**	**4**
19. I feel the need to avoid conflict, and keep quiet even when someone else mistreats me.	**NO**	**YES**	**1**	**2**	**3**	**4**